

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>30 E. Bradley Lane</u>	
3. NAME OF DECEASED (Type or Print) <u>Catherine Marie Abbott</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>30</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 1, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>74</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Costello</u>		14. MOTHER'S MAIDEN NAME <u>Gorman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Ira H. Abbott 30 E. Bradley Lane</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Acute Myocardial Failure with Pulmonary Edema</u> <u>3 days.</u>			
Antecedent cause(s) (b) <u>Diabetes Mellitus, severe</u> <u>25 yrs.</u>			
(c) <u>Hypertensive Cardio-Vascular-Renal Disease</u> <u>15 yrs.</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Cholecystitis</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>48</u> , to <u>April 30</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>29 April</u> , 19 <u>51</u> , and that death occurred at <u>7:30 A.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Stewart M. Webb</u>		ADDRESS <u>3921 Ingomar St. N.W.</u>	
DATE SIGNED <u>4-30-51</u>			
23. BURIAL, CREMATION REMOVAL, (Specify) <u>Burial-transit</u>		DATE THEREOF <u>May 1, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Pinehill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Wolfeboro, N. Hampshire</u>	
DATE REC'D BY LOCAL REG. <u>4/30/51</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

3855

RECEIVED

MAY 2 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

3856

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH: COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OLNEY, MD.		CITY (If outside corporate limits, write RURAL and give nearest town) OLNEY, MD.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MONTG. COUNTY GENERAL HOSPITAL		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) ALLAN	(Middle) McLANE	(Last) ABERT
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH MARCH 27, 1865
9. AGE last birthday 86 yrs.		10. BIRTHPLACE (State or foreign country) MARYLAND	11. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME CHARLES ABERT		14. MOTHER'S MAIDEN NAME HENRIETTA BACHE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. NONE	
17. INFORMANT AND ADDRESS HOSPITAL RECORD			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a)

Uremia

Antecedent cause(s) (b)

Urinary retention

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

Prostatic hypertrophy simple

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Mar 26, 1951, to April 7, 1951, that I last saw the deceased alive on April 7, 1951, and that death occurred at 11:20 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 9, 1951	Rockville Union	Rockville, Md
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4-9-51	Gertrude Lawler	Warner G. Humphrey	390916 Silver Spring, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A154

RECEIVED

APR 12 1951

BUREAU V. S.

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4901 Edgemoor Lane</u>		STREET ADDRESS (If rural, give location) <u>4901 Edgemoor Lane</u>	
3. NAME OF DECEASED (Type or Print) <u>Eugene</u>	(First) <u>G.</u> (Middle) <u>Cidams</u>	4. DATE OF DEATH <u>Apr 7 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7 July 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	9. AGE last birthday <u>64</u> yrs
11. BIRTHPLACE (State or foreign country) <u>Danville, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stephen Edward Adams</u>		14. MOTHER'S MAIDEN NAME <u>Sannie Dinsoid</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>579-42-8383</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Eugene G. Adams Bethesda, Md.</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary occlusion</u>		<u>Found dead in bath room floor.</u>
94a Antecedent cause(s) (b) <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE Frank J. Broschart M.D. (Degree or title) ADDRESS Quintland Maryland DATE SIGNED 4-7-51

23. RURAL, CREMATION REMOVAL (Specify) <u>Cremation</u>	DATE THEREOF <u>9 Apr 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	LOCATION (City, town, or county) <u>Quintland Maryland</u>
DATE REC'D BY LOCAL REG. <u>4-13-51</u>	REGISTRAR'S SIGNATURE <u>Helen L. Eckenfelder</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey, Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

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RECEIVED
APR 16 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

3858

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Montg</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Leytonville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Leytonville</u>	
TOWN <u>Leytonville</u>		TOWN <u>Leytonville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Govan Davis Armstrong</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Apr 11 1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Oct 30 - 1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President J. D. Armstrong Co Int'l Oil</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Midland Va</u>	9. AGE last birthday <u>49</u> yrs. <input type="checkbox"/> under 1 year <input type="checkbox"/> under 24 hrs
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEBANON B. ARMSTRONG</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE MILLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Esther Pumphrey Armstrong</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary occlusion</u>			<u>sudden death.</u>
Antecedent cause(s) (b) <u>4/20/1</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>94a</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>Frank J. Broochart M.D. Gaithersburg Md</u>		DATE SIGNED <u>4-11-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>		DATE THEREOF <u>April 14 - 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Leytonville Md</u>		LOCATION (City, town, or county) (State) <u>Montgomery Co Md</u>	
DATE REC'D BY LOCAL REG. <u>4/13/51</u>		REGISTRAR'S SIGNATURE <u>Lawrence D. Bell</u>	
FUNERAL DIRECTOR <u>Ray W. Barber</u>		ADDRESS <u>Leytonville Md</u>	

VS. A15A T

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Pa.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Colesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pittsburgh</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Jolliffe Nursing Home</u>		STREET ADDRESS (If rural, give location) <u></u>	
3. NAME OF DECEASED (Type or Print) <u>ELLA</u> (First) <u>May</u> (Middle) <u>Baker</u> (Last)		4. DATE OF DEATH <u>April 16</u> (Month) (Day) (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 10, 1862</u>
9. AGE, last birthday <u>89</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Bakerstown, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Ross</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Pearce</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT AND ADDRESS <u>Mrs. W.E. Branthover</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

15-7X Immediate cause (a) Carcinoma of head of Pancreas 8 mos

46g Antecedent cause(s) (b) Mod. Chronic Dehydration 8 mos

(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Mod. Chronic Dehydration</u>	12. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Aug. 6, 1950, to Jan. 16, 1957, that I last saw the deceased alive on Jan. 13, 1957, and that death occurred at 2:19 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>4/17/57</u>	DATE THEREOF	NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	LOCATION (City, town, or county) <u>Stna. Penna.</u>	(State)
DATE REC'D BY LOCAL REG. <u>April 17/57</u>	REGISTRAR'S SIGNATURE <u>Frances Potter</u>	24. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u>	ADDRESS <u>2901-14th</u>	

Wash., D.C.

MARGIN RESERVED FOR BINDING

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VS. A15

RECEIVED

APR 19 1951

BUREAU V. S.

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Virginia</u> COUNTY <u>Arlington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>	
TOWN <u>Bethesda</u>		TOWN <u>Arlington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5612 Wisconsin Ave</u>		STREET ADDRESS (If rural, give location) <u>4025 S. 9th St.</u>	
3. NAME OF DECEASED (First) <u>Abigail</u> (Middle) <u>Jackson</u> (Last) <u>BARNUM</u>		4. DATE OF DEATH (Month) <u>Apr</u> (Day) <u>23</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Oct 10, 1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter - self & const. co.</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>82</u> yrs.
13. FATHER'S NAME <u>Wm. J. Barnum</u>		11. BIRTHPLACE (State or foreign country) <u>Ill.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16. SOCIAL SECURITY NO. <u>no</u>		14. MOTHER'S MAIDEN NAME <u>G. M. Gill</u>	
17. INFORMANT AND ADDRESS <u>Mrs Ethel Hamblen</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) acute cardiac dilatationAntecedent cause(s) (b) carcinoma of liver

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

3 hrs3 yrsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, county)	(State)
<u>4/25/51</u>	<u>4/25/51</u>	<u>Columbia Park</u>	<u>Arlington Va</u>	
DATE REC'D BY LOCAL REG. <u>April 23 1951</u>	REGISTRAR'S SIGNATURE <u>Frances Teller</u>	24. FUNERAL DIRECTOR <u>Cheng Chong Funeral Home, 5103 7th Ave</u>	ADDRESS	

MARGIN RESERVED FOR BINDING

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APR 25 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

3861

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY: <u>Prince George's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> TOWN <u>74003</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Croftdale</u> TOWN <u>Washington 18</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u> <u>8600 Old Georgetown Rd</u>		STREET ADDRESS (If rural, give location) <u>4904 Russell Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Laura</u>	(Middle)	(Last) <u>Barnell</u>
4. DATE OF DEATH	(Month) <u>4</u>	(Day) <u>8</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1-18-66</u>
9. AGE last birthday <u>85</u> yrs.	If under 1 year Months Days	If under 24 hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY? <u>England</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>Benjamin Ward</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

903.0 Immediate cause (a) toxemia

6 wks

Antecedent cause(s)

1860 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) chronic nephritis

5 yrs

(c) Fractured left femur

2-16-51

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Widespread cystic bone disease

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY 2-16-51 m.INJURY OCCURRED While at Work ☐ Not While at Work ☒

HOW DID INJURY OCCUR?

fell while walking on level floor22. I hereby certify that I attended the deceased from 2-16-51 to 4-8-51, that I last saw the deceasedalive on 4-7-51, 19....., and that death occurred at 4:20 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

John O. Rabben MD 7930 Georgia Ave Silver Spring Md

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4-8-51Helen Kuryak1212 N. Howard Co. 2901 14th StRich, D.C.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 12 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

3862

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>District of Columbia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>3010 Woodland Drive, N.W.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Paul</u> <u>Henry</u> <u>BASTEDO</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 18,</u> <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 25, 1887</u>
9. AGE last birthday <u>64</u> yrs.		10. If under 1 year Months <u>01</u> Days <u>24</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Walter B. BASTEDO</u>		14. MOTHER'S MAIDEN NAME <u>Catherine A. HENRY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW I-11</u>		16. SOCIAL SECURITY NO. <u>- - - - -</u>	
17. INFORMANT AND ADDRESS <u>Wife: Helen P. BASTEDO</u>			

18. MEDICAL CERTIFICATION Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Anuria

Antecedent cause(s)

(b)

Ante-lapse to both Anterior

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

From Carcinoma Rectum11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Mar 6, 1951, to Apr 18, 1951, that I last saw the deceasedalive on Apr 18, 1951, and that death occurred at 5:53 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

T. N. QUILTER, Lt., MC, USNU. S. NAVAL HOSPITALApril 18, 1951

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Apr 20, 1951</u>	<u>Arlington National</u>	<u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Apr 18, 1951</u>	<u>Edna Whittington</u>	<u>S. H. Hines</u>	<u>2901 14th Street, NW, Washington, D. C.</u>	

W.R.W. & 290 916

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

APR 20 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> TOWN STREET ADDRESS (If rural, give location) <u>4912 Hampden Lane</u>	
3. NAME OF DECEASED (Type or Print) First: <u>Mary</u> Middle: <u>Lillian</u> Last: <u>Bauskett</u>	4. DATE OF DEATH (Month) <u>4</u> (Day) <u>10</u> (Year) <u>1951</u>	5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>12-14-1874</u>	9. AGE last birthday <u>76</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Social Worker</u>
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	13. FATHER'S NAME <u>John Bauskett</u>	14. MOTHER'S MAIDEN NAME <u>Helen V. Niernsee</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>Sp. Arm. War</u>	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS <u>Katherine Calhoun - 4912 Hampden Lane (Sister)</u>	18. MEDICAL CERTIFICATION
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebrovascular Hemorrhage</u>			<u>2 yrs</u>
Antecedent cause(s) (b) <u>Hypertensive Cardiovascular Disease</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>chronic peptic ulcer</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>46</u> , to <u>4/10</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>4/10</u> , 19 <u>51</u> , and that death occurred at <u>11:45</u> p.m., from the causes and on the date stated above.			
SIGNATURE <u>J. L. Marks, M.D.</u>		ADDRESS <u>6306 Wisconsin Ave Chevy Chase, Md</u>	
23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Buried</u>	<u>4/13/51</u>	<u>Belington National</u>	<u>Belington, Virginia</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>4-11-51</u>	<u>Helen S. Eckhardt</u>	<u>Robert A. Humphrey</u>	<u>Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 12 1961

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3864

Items 8, 9 on:

FILE No. G 132 MAY 14 1951

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Poolesville, P.O. - 74</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Poolesville, Md Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Marian</u>	(Middle) <u>William</u>	(Last) <u>Beall</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4/26/1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Team Hauler (active)</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>65</u> yrs.
11. FATHER'S NAME <u>James Beall</u>		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>	
13. MOTHER'S MAIDEN NAME <u>Catherine Morrison</u>		14. INFORMANT <u>Raymond Beall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. (If yes, give war or dates of service)		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Uremia; Chronic nephritis, arteriosclerotic
Kidney

INTERVAL BETWEEN ONSET AND DEATH

10 day

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic
(c) Generalized Arteriosclerosis

24 months

5 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from February 1951, to April 1, 1951, that I last saw the deceased alive on 27 Apr., 1951, and that death occurred at 9:30 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4/29/51</u>	<u>Monocacy</u>	<u>Beallsville, Md</u>	
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Apr. 28/51</u>	<u>John W. Beall</u>	<u>William B. Hilton</u>	<u>820105</u> <u>Barresville, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-1



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

3865

1. PLACE OF DEATH - COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Marley Park	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital		STREET ADDRESS (If rural, give location) Box 14, Greenway Rd.	
3. NAME OF DECEASED (First) Roland (Middle) James (Last) BONNEVILLE		4. DATE OF DEATH (Month) April (Day) 25 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH July 21, 1926 24 yrs. 09 Months 04 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Petty Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	11. BIRTHPLACE (State or foreign country) Florida
13. FATHER'S NAME Raymond J. BONNEVILLE		14. MOTHER'S MAIDEN NAME Olive HOWEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY No. - - - - -	
17. INFORMANT AND ADDRESS Uncle: Robert L. BONNEVILLE		18. MEDICAL CERTIFICATION Same as item # 2	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Uremia			3 mos.
Antecedent cause(s) (b) chronic glomerulonephritis			2 years
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) congenital Polycystic Disease of Kidneys			Life
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov. 10, 1950 , to Apr 25, 1951 , that I last saw the deceased alive on Apr 25, 1951 , and that death occurred at 3:53 P.m. , from the causes and on the date stated above.			
SIGNATURE F. B. ROGERS (Degree or title)		ADDRESS U.S. NAVAL HOSPITAL DATE SIGNED April 26, 1951	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Apr 28, 1951 NAME OF CEMETERY OR CREMATORY Glen Haven Memorial LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
DATE REC'D BY LOCAL REG. Apr 26, 1951		24. FUNERAL DIRECTOR'S SIGNATURE Edith Whittington ADDRESS Wastler Funeral Home, 301 East Capitol Street, Washington, D.C.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415-1

MINISTRE DU SANTE DEPARTEMENT DE SANTE

MINISTRE DU SANTE DEPARTEMENT DE SANTE

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
DATE OF REGISTRATION		TIME OF REGISTRATION		PLACE OF REGISTRATION		CAUSE OF REGISTRATION		MANNER OF REGISTRATION	

RECEIVED

APR 27 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

3866

1. PLACE OF DEATH - COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8201 Schrider Street, Apt. #6</u>		STREET ADDRESS <u>8201 Schrider Street, Apt. 6.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>DANIEL</u>	(Middle) <u>W.</u>	(Last) <u>BOWIE</u>
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>3</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 17, 1897</u>
9. AGE last birthday <u>53</u> yrs.	If under 1 year Months <u>3</u> Days <u>19</u>	If under 24 hrs. Hours <u>51</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner, Business Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Earnings</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel W. Bowie</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Russell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Mildred F. Bowie (Wife) 8201 Schrider St. S.D. Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/8, 1949, to 4/3, 1951, that I last saw the deceased alive on 4/3, 1951, and that death occurred at 11:30 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

April 4, 1951
Francis Walter
Arthur Walters, 254 Carroll St. N.W. D.C.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

290 658



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Virginia</u> COUNTY <u>Alexandria</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Alexandria</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>107 East Raymond Avenue</u> ✓	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Benjamin Franklin BROOKS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 22, 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 14, 1899</u>
9. AGE last birthday <u>51</u> yrs. <u>04</u> Months <u>08</u> Days		10. If under 1 year If under 24 hrs. Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Economist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Gov't</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Benjamin BROOKS</u>		14. MOTHER'S MAIDEN NAME <u>Emma AULT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WW I</u>		16. SOCIAL SECURITY No. <u>- - - - -</u>	
17. INFORMANT AND ADDRESS <u>Wife: Pansy M. BROOKS</u>			

18. MEDICAL CERTIFICATION Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) CARCINOMA, RECTUM

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb 2, 1951, to Apr 22, 1951, that I last saw the deceased alive on Apr 22, 1951, and that death occurred at 8:15 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

H. A. GRAVES, Jr., LTJG, MCR, USNR U.S. NAVAL HOSPITAL April 23, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>Apr 23, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Tacoma Cemetery</u>	LOCATION (City, town, or county) (State) <u>Tacoma, Washington</u>
DATE REC'D BY LOCAL REG. <u>Apr 23, 1951</u>	REGISTRAR'S SIGNATURE <u>Edith Whittington</u>	24. FUNERAL DIRECTOR <u>W. W. Chambers, 3072 M Street, NW,</u>	ADDRESS <u>Washington, D.C.</u>

081916 R.A.R.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

APR 24 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

3868

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Pennsylvania</u> COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>McKeesport</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>1121 Washington Street</u>	
3. NAME OF DECEASED (First) <u>Frank</u> (Middle) <u>(none)</u> (Last) <u>BUCHANAN</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>27</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 1, 1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
13. FATHER'S NAME <u>Thomas BUCHANAN</u>		14. MOTHER'S MAIDEN NAME <u>Mary CAMPBELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>- - - - -</u>		17. INFORMANT AND ADDRESS <u>Wife: Vera Daerr BUCHANAN</u>	
16. SOCIAL SECURITY No. <u>- - - - -</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Same as item # 2	
Immediate cause (a) <u>Bleeding esophageal varices</u>		INTERVAL BETWEEN ONSET AND DEATH	
Antecedent cause(s) (b) <u>Cirrhosis of the liver</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>- - - - -</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>25 April 51</u>		19b. MAJOR FINDINGS OF OPERATION <u>Cirrhosis of the liver</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>INJURY</u>		PLACE (Home, farm, factory, street, OF office hldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at <input type="checkbox"/> Not While at <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mar 18, 1951</u> to <u>Apr 27, 1951</u> , that I last saw the deceased alive on <u>Apr 27, 1951</u> , and that death occurred at <u>9:02 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Paul Trautman</u>		ADDRESS <u>Paul TRAUTMAN, LTJG, MCR, USNR U.S. NAVAL HOSPITAL</u>	
DATE SIGNED <u>April 28, 1951</u>			
23. BURIAL CREMATION REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>Apr 28, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>McKeesport, Pennsylvania</u>		LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey, 7557 Wisconsin Avenue, Bethesda, Maryland.</u>			
DATE REC'D BY LOCAL REG. <u>Apr 28, 1951</u>		REGISTRAR'S SIGNATURE <u>Edith Whittington</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

055879 ccb.

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

MAY 2 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

3869

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>		STREET ADDRESS (If rural, give location) <u>134 Maple Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Thomas H. Burriss</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 24 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10-18-87</u>
9. AGE last birthday <u>63</u> yrs.		10. DATE OF DEATH (Month) (Day) (Year) <u>April 24 1951</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shifting Night Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Montgomery County Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Thomas Henry Burriss</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Gray</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>578-03-5241</u>	
17. INFORMANT AND ADDRESS <u>Henry M. Burriss 134 Maple Ave Kensington Md</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Diabetic Coma & shock & anuria

INTERVAL BETWEEN ONSET AND DEATH

?

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Adenocarcinoma of bladder

2 years

(c) Carcinoma of prostate

2 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

None

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

None

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY	INJURY OCCURRED While at <input type="checkbox"/> Not While <input type="checkbox"/> Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 4-23-1951, to 4-24-1951, that I last saw the deceasedalive on 4-24-1951, and that death occurred at 11:05 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Alan Q. DonM.D.Suburban Hosp.4-24-51

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 28, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. Carmel M.C.</u>	LOCATION (City, town, or county) <u>Montgomery Co Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>5-8-51</u>	REGISTRAR'S SIGNATURE <u>Beauregard Thompson</u>	24. FUNERAL DIRECTOR <u>Prof W. Barker</u>	ADDRESS <u>Lintonville Md</u>	

970-667

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 10 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

3870

1. PLACE OF DEATH - COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
TOWN <u>Bethesda</u>		TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5625 Oak Place</u>		STREET ADDRESS (If rural, give location) <u>5625 Oak Place</u>	
3. NAME OF DECEASED (First) <u>Ellen</u> (Middle) <u>Elizabeth</u> (Last) <u>Carpenter</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>18</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>5 Nov 1879</u>
9. AGE last birthday <u>71</u> yrs. <u>4</u> Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael Brady</u>		14. MOTHER'S MAIDEN NAME <u>Mary Gleason</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>5625 Oak Place</u>		18. MEDICAL CERTIFICATION	
19. DATE OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Intestinal Obstruction - cause undetermined</u>		<u>1 week</u>
Antecedent cause(s) (b) <u>420.0</u>		<u>6 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>93d</u>	<u>Hypertension</u> <u>Arteriosclerotic heart disease</u>	<u>3 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 4/8, 1951, to 4/18, 1951, that I last saw the deceased alive on 4/16, 1951, and that death occurred at 2:30 A. m., from the causes and on the date stated above.

SIGNATURE Benjamin W. D. ADDRESS 4200 Beltsville Parkway Bethesda Md 4/18/51 DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>19 April 1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. Peters</u>	LOCATION (City, town, or county) <u>Belleville, New Jersey</u> (State)
DATE REC'D BY LOCAL REG. <u>4-20-51</u>		REGISTRAR'S SIGNATURE <u>Heles J. Eberfeldt</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 23 1954
BUREAU V. B.

APR 23 1954

APR 23 1958
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Olney</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Brookeville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County General Hospital, Inc.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>George</u> (Middle) <u>Franklin</u> (Last) <u>Cashell</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>28</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M.</u>	8. DATE OF BIRTH <u>3/13/77</u>
9. AGE last birthday <u>74</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George W. Cashell</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Hobbs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Hospital records</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) UremiaAntecedent cause(s) (b) NephrosclerosisDisease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 131a

INTERVAL BETWEEN ONSET AND DEATH

1 month5 yearsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June 6, 1948, to April 28, 1951, that I last saw the deceased alive on April 27, 1951, and that death occurred at 4:50 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Charles S. Whitaker, B.O., Clarksville, Md.4/28/51

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>April 30, 1951</u>	<u>St. Carmel</u>	<u>Montgomery Co</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4-30-51</u>	<u>Esther B. Lawler</u>	<u>Ray W. Barber</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 2 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

3872

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>D.C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Takoma Park</u> LENGTH OF STAY (in this place) <u>15 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cedar Haven Rest Home</u>		STREET ADDRESS (If rural, give location) <u>1325 Elmwood St. N.W.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Hattie</u> (Middle) <u>Lamb</u> (Last) <u>Castens</u>	4. DATE OF DEATH	(Month) <u>April</u> (Day) <u>17</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12/3/1867</u>
9. AGE last birthday <u>83</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Lyman H. Lamb</u>	14. MOTHER'S MAIDEN NAME <u>Margaret C. Wright</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>
16. SOCIAL SECURITY No. <u>None</u>	17. INFORMANT AND ADDRESS <u>Mrs. H. D. Cooper, 1220 Jefferson St. N.W.</u>		

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>(a) Gastro-intestinal hemorrhage, etiology not determined</u>			<u>30 hrs.</u>
Antecedent cause(s) <u>(b) Hypertension</u>			<u>Years</u>
<u>(c) Arteriosclerotic heart disease</u>			<u>Years</u>
II. OTHER SIGNIFICANT CONDITIONS			<u>Years</u>
Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility</u>			
19a. DATE OF OPERATION <u>1-31-51</u>	19b. MAJOR FINDINGS OF OPERATION <u>Open reduction, nailing rt. hip fracture</u>	20. AUTOPSY?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>Accident</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	(CITY OR TOWN) <u>Washington</u>	(COUNTY) <u>D.C.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Jan. 26, 1951 3P</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Slipped and fell in bathroom.</u>	

22. I hereby certify that I attended the deceased from April 11, 1951, to April 17, 1951, that I last saw the deceased alive on April 17, 1951, and that death occurred at 2:40 P.m., from the causes and on the date stated above.

SIGNATURE <u>Wallace H. Mook M.D.</u>	(Degree or title)	ADDRESS <u>Takoma Park 12 Md.</u>	DATE SIGNED <u>4/17/51</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>4-29-51</u>	DATE	NAME OF CEMETERY OR CREMATORY <u>Congressional Cem</u>	LOCATION (City, town, or county) (State) <u>Wash. DC</u>
DATE REC'D BY LOCAL REG. <u>4-17-51</u>	REGISTRAR'S SIGNATURE <u>J. Moom Nott</u>	24. FUNERAL DIRECTOR <u>W. W. Chambers Co.</u>	ADDRESS <u>1400 Chapin St. N.W. Wash. DC</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 23 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

3877

Reg. Dist. No. 223

1. PLACE OF DEATH COUNTY <u>Montg</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Takoma Park</u> LENGTH OF STAY (In this place) <u>8 mo</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Takoma Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100 Balto Ave.</u>		STREET ADDRESS (If rural, give location) <u>100 Balto Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>William E Chittenden</u>		4. DATE OF DEATH (Month) <u>Apr</u> (Day) <u>20</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>February 8, 1869</u>
9. AGE last birthday <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Printer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>		11. BIRTHPLACE (State or foreign country) <u>Milford, Delaware</u>	
13. FATHER'S NAME <u>Arson Chittenden</u>		14. MOTHER'S MAIDEN NAME <u>Emma Draft</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>not available</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Lucille C. Wallace, 5600 Colorado Ave. NW</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary occlusion</u> Antecedent cause(s) (b) <u>420.1</u> <u>94a</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>sudden death</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>Frank J. Brochart M.D.</u> ADDRESS <u>Yarborough md</u> DATE SIGNED <u>4-20-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>	DATE THEREOF <u>April 20, 1951</u>
NAME OF CEMETERY OR CREMATORY <u>Dean Hill Cemetery</u>	LOCATION City, town, or county (State) <u>Pine Co. Md</u>
DATE REC'D BY LOCAL REG. <u>4-20-51</u>	24. FUNERAL DIRECTOR <u>F. H. Hamm</u> ADDRESS <u>254 Canal St NW DC</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

290 45 Takoma Park

RECEIVED
APR 23 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>WIS.</u> COUNTY <u>Milwaukee</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Milwaukee</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>		STREET ADDRESS <u>918 South 30th St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Martin</u> (Middle) <u>James</u> (Last) <u>Cody</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>29</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 6, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cutler-Hammer Co.</u>	9. AGE last birthday <u>57</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Matthew Cody</u>		14. MOTHER'S MAIDEN NAME <u>Rose P. Nelson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>388-03-9662</u>	
17. INFORMANT AND ADDRESS <u>Daughter June E. Cody 1600 Kaira Rd. 'Whooten, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Hemorrhage

Antecedent cause(s)

(b) Cerebral arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

8 days10 yrsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify) None PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☒22. I hereby certify that I attended the deceased from 21 April, 1951, to 29 April, 1951, that I last saw the deceasedalive on 28 April, 1951, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Trans. & Burial DATE THEREOF May 3, 1951 | NAME OF CEMETERY OR CREMATORY unknown | LOCATION (City, town, or county) Milwaukee, Wisconsin | (State) |

DATE REC'D BY LOCAL REG. Apr 30/51

REGISTRAR'S SIGNATURE Frances Potter

24. FUNERAL DIRECTOR Wm. R. D. Humphrey

ADDRESS

8434 Ga. Ave., Silver Spring

Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 1 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

3874

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
TOWN <u>Cherry Chase</u>		TOWN <u>Cherry Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>716 E. Leland St.</u>		STREET ADDRESS (If rural, give location) <u>716 E. Leland St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Grace</u> (Middle) <u>Yhuelle</u> (Last) <u>Cole</u>		4. DATE OF DEATH (Month) <u>Apr</u> (Day) <u>28</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12-12-1874</u>
9. AGE last birthday <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired government clerk</u>	
11. BIRTHPLACE (State or foreign country) <u>Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John M. Grunells</u>		14. MOTHER'S MAIDEN NAME <u>Frances Sillman</u> (HILLMAN)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Esther H. Cole</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary occlusion</u>		<u>Sudden death.</u>
Antecedent cause(s) (b) <u>420.1</u> <u>94a</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, or office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>4-30-51</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	LOCATION (City, town, or county) (State) <u>Prince Georges Co Md</u>
DATE REC'D BY LOCAL REG <u>4/30/51</u>	REGISTRAR'S SIGNATURE <u>Frances Heller</u>	24. FUNERAL DIRECTOR <u>The SH Hines Co Wash. D.C.</u>	ADDRESS

390916

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 1 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

3875

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>D. C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital, 8600 Old Georgetown Rd.</u>		STREET ADDRESS (If rural, give location) <u>1936 35th St., N.W.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Helen</u> (Middle) <u>Geerson</u> (Last) <u>Levin</u>	4. DATE OF DEATH	(Month) <u>4</u> (Day) <u>2</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 13, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>74</u> yrs. <u>3</u> months <u>19</u> days	If under 1 year If under 24 hrs. Months Days Hours Min.
13. FATHER'S NAME <u>Andrew Grant L. Hoffman</u>		14. MOTHER'S MAIDEN NAME <u>Helen Mary L. Hoffman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pneumonia, Lobar

Antecedent cause(s)

(b) Senility

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) Hypertensive Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

4 days

20 yrs +

20 yrs +

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 3/10, 1951, to 4/1, 1951, that I last saw the deceased

alive on 3/1, 1951, and that death occurred at 5:10 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

J. D. Damian M.D. 2741 34th St. N.W. April 2 1951

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4/4/51</u>	<u>St. Agatha</u>	<u>Capitol Hill</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4-2-51</u>	<u>Helen Kinnear</u>	<u>Joe F. Brischler</u>	<u>3034 M St N</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 211

3876

1. PLACE OF DEATH: COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>MONT.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HYATTSTOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HYATTSTOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EDNA</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>EDNA</u>	(Middle) <u>M.</u>	(Last) <u>COOKMAN</u>
4. DATE OF DEATH	(Month) <u>APRIL</u>	(Day) <u>20</u>	(Year) <u>1951</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>JUNE 1, 1869</u>
9. AGE last birthday <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>EZEKIAL COOKMAN</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES CRALLE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>MRS. L.E. McGILL - HYATTSTOWN, MD.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Thrombosis

4/20.1 Antecedent cause(s)
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arterio Sclerosis

(c)

INTERVAL BETWEEN ONSET AND DEATH

4 days
10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY

INJURY OCCURRED
While at Not While
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 10, 1951, to Apr 20, 1951, that I last saw the deceased alive on Apr 16, 1951, and that death occurred at 1:30 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Ernest P. Roof, M.D., New Market, Maryland

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG. April 21, 1951

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Della W. Burdette

James H. Bayne, Inc., 312 Pa. Ave., N.E.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

MAR 25 1958

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK.. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Item 18, 19a on:

M No. G 132 MAY 15 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3878

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rockville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>216 Highland Avenue</u>		STREET ADDRESS (If rural, give location) <u>216 Highland Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Ellen</u>	(Middle) <u>E.</u>	(Last) <u>Craigie</u>
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>Apr. 24, 1883</u>
9. AGE last birthday <u>67</u> yrs.		10. DATE OF DEATH <u>APR 21 1951</u>	
11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew Edward</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Edward</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>William K. Craigie, Sr. - Husband</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Cardio-respiratory failure30 min.

Antecedent cause(s)

(b)

Carcinomatous & acute

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Primary site - carcinoma of the colon
cachexia (5/15/51 aka)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

6 mos. prior to deathCarcinoma of the colon resectedYes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from on Apr. 21, 1951, to 5:10 P., 19....., that I last saw the deceasedalive on APR 21 1951, and that death occurred at 5:10 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BurialApril 24, '51 Rockville UnionRockville Maryland

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4-23-51Helen S. EichenfelderRobert A. HumphreyBethesda, Md.

RECEIVED

APR 24 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223-3879

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium & Hospital</u>		STREET ADDRESS (If rural, give location) <u>213 Raymond St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Grace</u> (Middle) <u>Maude</u> (Last) <u>Crandall</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>26</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12-29-79</u> 9. AGE last birthday <u>71</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Jefferson, Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Harrison Hake</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Hake</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Hospital Records</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Coronary Thrombosis with infarction(b) Hypertensive Cardiovascular Renal disease(c) Right pulmonary embolism(d) Left bronchopneumonia & cerebral embolism

INTERVAL BETWEEN ONSET AND DEATH

daysyearsdays11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF injury bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 3-26, 1951, to 4-26, 1951, that I last saw the deceasedalive on 4-26, 1951, and that death occurred at 8:55 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4-30-51</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington Park</u>	LOCATION (City, town, or county) <u>Arlynton</u>	(State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>4-16-51</u>	REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u>	24. FUNERAL DIRECTOR <u>Joseph H. H. H. H.</u>	ADDRESS <u>1756 Pa. Ave. N.W.</u> <u>Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 1 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

3880

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>District of Columbia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>4911 Arkansas Avenue, NW</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Eleanor</u>	(Middle) <u>Katherine</u>	(Last) <u>CRONAN</u>
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>2</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 28, 1888</u>
9. AGE last birthday <u>62</u> yrs. <u>07</u> mos. <u>04</u> days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Elmer E. STITZEL</u>		14. MOTHER'S MAIDEN NAME <u>Mary UNK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>---</u>	
17. INFORMANT AND ADDRESS <u>Husband: Phillip G. CRONAN</u>		18. MEDICAL CERTIFICATION <u>Same as item # 2</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Hypertensive Suggestion (warlike)</u>			<u>12 hrs.</u>
Antecedent cause(s) (b) <u>Atherosclerotic Heart Disease</u>			<u>Indef.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
SUICIDE HOMICIDE	INJURY		
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mar 29</u> , 19 <u>51</u> , to <u>Apr 2</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Apr 2</u> , 19 <u>51</u> , and that death occurred at <u>9:35 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>E. M. SPAULDING</u>		ADDRESS <u>U.S. NAVAL HOSPITAL</u>	
DATE SIGNED <u>April 2, 1951</u>			
23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Apr 6, 1951</u>	<u>Arlington National</u>	<u>Arlington, Virginia</u>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Apr 11 2, 1951</u>	<u>Edna Washington</u>	<u>Deal Funeral Home, 4812 Georgia Avenue, NW, Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



ITEM 7:
MARRIED.

letter from Capt. Gross, USN HOSP Bethesda, filmed 5-4-51 G132 L

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

3881

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>4716 Chevy Chase Blvd.</u>	
3. NAME OF DECEASED (First) <u>John</u> (Middle) <u>Hoff</u> (Last) <u>CROSS</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>April 29, 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Apr 18, 1871</u>
9. AGE last birthday <u>80</u> yrs. <u>00</u> Months <u>11</u> Days		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>John T. CROSS</u> WIFE: <u>Florence G. Cross</u> 716 Gladstone, BaltoMd.			
14. MOTHER'S MAIDEN NAME <u>Mary WEDDIGEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>- - - - -</u>	
17. INFORMANT AND ADDRESS <u>Son: Howard CROSS</u>			

18. MEDICAL CERTIFICATION Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <u>PYELONEPHRITIS, ACUTE (WITH UREMIA)</u>	INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u>
Antecedent cause(s) (b) <u>HYPERTROPHY OF PROSTATE, BENIGN</u>	<u>15 yrs.</u>
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>ARTERIOSCLEROSIS, GENERALIZED (MARKED)</u>	<u>20 yrs.</u>

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. HERNIA, ING., INDIR., INCARCERATED (WITH PERITONITIS)

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE HOMICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 16, 1951, to Apr 29, 1951, that I last saw the deceased alive on Apr 29, 1951, and that death occurred at 1:44 P.m., from the causes and on the date stated above.

SIGNATURE J. S. HANTEN (Degree or title) CDR, MC, USN ADDRESS U.S. NAVAL HOSPITAL DATE SIGNED April 30, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 2, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore, Maryland</u>
DATE REC'D BY LOCAL REG. <u>Apr 30, 1951</u>	REGISTRAR'S SIGNATURE <u>Edith Whittington</u>	24. FUNERAL DIRECTOR <u>Donovan Funeral Home</u>	ADDRESS <u>3818 Roland Avenue, Baltimore, Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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7713

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

First Name	John	Age	45
Last Name	Smith	Sex	Male
Place of Birth	New York	Occupation	Teacher
Date of Death	Jan 15 1951	Time of Death	10:30 AM
Place of Death	Home	Cause of Death	Heart Disease
Physician	Dr. J. A. Brown	Signature	[Signature]
Registrar	[Signature]	Official Seal	[Seal]

RECORDED

BUREAU V. S.

2 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

3882

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Deale, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery Caben Hosp.</u>		STREET ADDRESS (If rural, give location) <u>None</u>	
3. NAME OF DECEASED (First) <u>Eliza</u>	(Middle) <u>None</u>	(Last) <u>Crofts</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>16</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 18 71</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>80</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rose Lobega</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Chester Crofts - Son - Deale, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Chronic hypertensive cardiovascular disease

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Diabetes mellitus

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

20 yrs20 + yrs

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/28, 1951, to 4/16, 1951, that I last saw the deceasedalive on 4/15, 1951, and that death occurred at 2:55 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

A. O. BonifantM.D.Sandy Spring, Md.4/16/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4-16-51Antoine B. FowlerWander E. HumphreySilversSandy Spring, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 18 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Olney</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mont. Co. Gen. Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Francis</u>	(Middle) <u>F.</u>	(Last) <u>Dahler</u>
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>10</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 29-1887</u>
9. AGE last birthday <u>63 yrs.</u>		10. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
11. CITIZEN OF WHAT COUNTRY <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Agusta Dahler</u>		14. MOTHER'S MAIDEN NAME <u>Amelia L. Gasch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mrs Mabel S. Dahler, Clarksburg, Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Bilateral bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

3 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic glomerulonephritis2 years(c) Hypertrophic arthritis, generalized5 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Silicosis10 years

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June 15, 1947, to April 10, 1951, that I last saw the deceasedalive on April 9, 1951, and that death occurred at 3:00 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Apr. 13, 1951</u>	<u>Bethesda</u>	<u>Browningsville</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4-12-51</u>	<u>Antonie B. Lawler</u>	<u>Olin L. Molesworth</u>	<u>Damascus, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

641916

RECEIVED

APR 16 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3884

CERTIFICATE OF DEATH

Reg. Dist. No. 2/6

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Virginia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Alexandria</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban 6700 old Georgetown rd.</u>		STREET ADDRESS <u>1744 Richmond Hwy</u>	
3. NAME OF DECEASED (Type or Print) <u>JOHN W DAVIS</u>		4. DATE OF DEATH <u>Apr 4 - 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Mar</u>	8. DATE OF BIRTH <u>Sept 9 1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	9. AGE last birthday <u>66</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Trenton Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Davis</u>		14. MOTHER'S MAIDEN NAME <u>Celia Marshall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Medical chart (Hospital) of Patient</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause		(a) <u>Acute Congestive Heart Failure with Pulmonary Edema</u>		<u>2 hrs.</u>	
Antecedent cause(s)		(b) <u>Post-Operative Gastric Resection</u>		<u>4 days.</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) <u>Bleeding Peptic Ulcer</u>		<u>4 yrs. +</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <u>Mar. 31, 1951</u>		19b. MAJOR FINDINGS OF OPERATION <u>Bleeding Peptic Ulcer</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June, 1947, to Apr 4, 1951, that I last saw the deceased alive on Apr 3, 1951, and that death occurred at 5:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Wire funeral home mci 0138

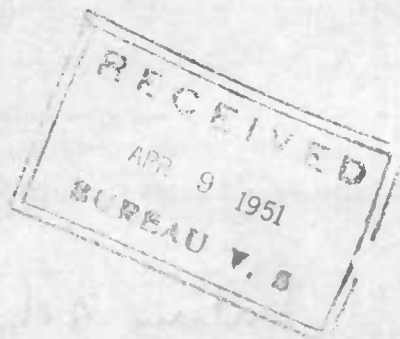
Wash DC

510246

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 218

3885

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Montgomery</u> COUNTY <u>Wm.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Maryland Rest Home</u>		STREET ADDRESS (If rural, give location) <u>503 Southhampton Drive</u>	
3. NAME OF DECEASED (Type or Print) <u>CHARLES</u> (First) <u>C.</u> (Middle) <u>DEATLEY</u> (Last)	4. DATE OF DEATH <u>April 12</u> 1951 (Month) (Day) (Year)		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 23, 1874</u> 77 yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
10. FATHER'S NAME <u>James Deatley</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		13. SOCIAL SECURITY No. <u>1-1-1-1-1-1-1-1-1-1</u>	
14. MOTHER'S MAIDEN NAME <u>Marietta Price</u>		15. INFORMANT AND ADDRESS <u>Charles Deatley</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
Immediate cause (a) <u>Coronary of bladder + sigmoid</u>			
Antecedent cause(s) (b) <u>181X</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>52b</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>✓</u>	19b. MAJOR FINDINGS OF OPERATION <u>✓</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>✓</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>✓</u>	(CITY OR TOWN) <u>✓</u>	(COUNTY) <u>✓</u> (STATE) <u>✓</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>✓</u>	INJURY OCCURRED While at <u>✓</u> Not While <u>✓</u> Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>✓</u>	

22. I hereby certify that I attended the deceased from April 11, 1951, to April 12, 1951, that I last saw the deceased alive on April 11, 1951, and that death occurred at 8:30 A. m., from the causes and on the date stated above.

SIGNATURE William C. Miller, M.D., 7 Brooke Ave., Gaithersburg, Md. DATE SIGNED 4/12/51

23. BURIAL, CREMATION REMOVAL (Specify) ✓ DATE 4/14/51 NAME OF CEMETERY OR CREMATORY Progression LOCATION (City, town, or county) Washington, D.C. (State) D.C.

DATE REC'D BY LOCAL REG. Apr 12, 1951 REGISTRAR'S SIGNATURE Abundis G. Cooke 24. FUNERAL DIRECTOR J. W. ... ADDRESS 644 VVV Washington, D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

APR 16 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

3886

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>5500 Wis., Ave.,</u>	
3. NAME OF DECEASED (First) <u>BRENTIE</u> (Middle) <u>R.</u> (Last) <u>DELLINGER</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 17, 1978</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Va.</u>
13. FATHER'S NAME <u>O.G. Ridgeway</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Mrs. Emily D. Beall, Bethesda, Md.</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Hemorrhage,

INTERVAL BETWEEN ONSET AND DEATH

3 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Coronary-vascular-renal disease5 yrs.(c) Adenocarcinoma of rectum3 yrs

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 13, 1951, to Apr. 16, 1951, that I last saw the deceased alive on Apr. 16, 1951, and that death occurred at 3:15 p.m., from the causes and on the date stated above.

SIGNATURE

Cousins

(Degree or title)

ADDRESS

Ingram

DATE SIGNED

4-16-51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Apr. 17/51Frances PotterCheng Chue Funeral Home - 5103 Hain Ave Mt.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

3887

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Virginia COUNTY Arlington	
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) Arlington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural, give location) 104 South Columbus Street ✓	
3. NAME OF DECEASED (Type or Print) Jo Ann DIXON		4. DATE OF DEATH (Month) (Day) (Year) April 27, 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Feb 6, 1948
9. AGE last birthday 03 yrs. 02 Months 21 Days		10. If under 1 year 02 Months 21 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Thomas D. DIXON		14. MOTHER'S MAIDEN NAME Josephine H. KAFEL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, none, or unknown) NO (If yes, give war or dates of service) - - - - -		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT AND ADDRESS Father: Thomas D. DIXON			
18. MEDICAL CERTIFICATION Same as item # 2			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) CARDIAC ARREST			None
Antecedent cause(s) (b) APPENDICITIS, ACUTE WITH PERFORATION AND PERITONITIS			48 hrs
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY Apr 27, 1951		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Apr 27, 1951 , to Apr 27, 1951 , that I last saw the deceased alive on Apr 27, 1951 , and that death occurred at 4:55 P.m. , from the causes and on the date stated above.			
SIGNATURE H. S. ARNOLD, LTJG, MC, USN		ADDRESS U.S. NAVAL HOSPITAL	
DATE SIGNED April 27, 1951			
23. BURIAL CREMATION REMOVAL (Specify) Burial		DATE THEREOF Apr 30, 1951	
NAME OF CEMETERY OR CREMATORY Arlington National		LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Fitzgerald Funeral Home,		ADDRESS Arlington, Virginia	
DATE REC'D BY LOCAL REG. Apr 27, 1951		REGISTRAR'S SIGNATURE Edith Whittington	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAINTAIN STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
JAN 2 1951
BUREAU V. &

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

3888

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
TOWN <u>Suburban Hosp</u>		TOWN <u>8211 Meadowbrook La.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print) <u>MARY</u> (First) <u>K</u> (Middle) <u>DOCKERY</u> (Last)		4. DATE OF DEATH (Month) <u>APRIL</u> (Day) <u>29</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Mar 25, 1877</u>
9. AGE last birthday <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John McDermott</u>		14. MOTHER'S MAIDEN NAME <u>Ann Cox</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Ellen Dockery 8211 Meadowbrook La.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) AC. ANTERIOR MYOCARDIAL INFARCTION

Antecedent cause(s)

(b) GENERALIZED ARTERIO SCLEROSIS(c) ARTERIO-EMBOLISM BOTH FEMORALS AND BIFURCATION OF AORTA.(d) CONGESTIVE HEART FAILUREINTERVAL BETWEEN ONSET AND DEATH
13 APR. '51.27 APR. '51.16 APR. '51

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

NONE

19a. DATE OF OPERATION

NONE

19b. MAJOR FINDINGS OF OPERATION

NONE

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

NONE

PLACE (Home, farm, factory, street, OF office bldg., etc.)

INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

NONEINJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

NONE22. I hereby certify that I attended the deceased from 13 APR., 1951, to 29 APR., 1951, that I last saw the deceasedalive on 28 APR., 1951, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

SILVER SPRING, MD.

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 4-29-51

REGISTRAR'S SIGNATURE

Bessie M. Thompson

24. FUNERAL DIRECTOR

Deal Funeral Home

ADDRESS

4812 Rockwood Dr. Wash. DC.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MAY 10 1961
BUREAU W.S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

3889

Reg. Dist. No. 223-

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Sam. + Hosp.</u>		STREET ADDRESS <u>R 7 J 412</u>	
3. NAME OF DECEASED (Type or Print) <u>Hezekiah</u> (First) <u>Dodson</u> (Middle) <u>Dodson</u> (Last)		4. DATE OF DEATH (Month) <u>Apr.</u> (Day) <u>24</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>4-9-1883</u>
9. AGE last birthday <u>68</u> yrs.		10. AGE last birthday If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>driver - street car</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>motorman</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Dodson</u>		14. MOTHER'S MAIDEN NAME <u>Susan J. Burke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Flora J. Dodson</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs.</u>
Immediate cause (a) <u>Occlusion of Basilar artery</u> Antecedent cause(s) (b) <u>with softening of brain</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>Frank J. Brown</u>		ADDRESS <u>Washington, Md.</u>		DATE SIGNED <u>4-24-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>April 27, 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Brownsville</u>	
LOCATION (City, town, or county) (State) <u>Washington, Md.</u>		24. FUNERAL DIRECTOR <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St NW</u>	
DATE REC'D BY LOCAL REG. <u>4-24-51</u>		REGISTRAR'S SIGNATURE <u>J. Arthur Walters</u>		25. FUNERAL DIRECTOR <u>J. Arthur Walters</u>	

661516 Washington-12.10 C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU V. S.

Written permission received from both parents. Hoffmuth. Med. Record Librarian



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

3891

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8111 Custer Rd.</u>		STREET ADDRESS (If rural, give location) <u>8111 Custer Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Ida</u> (First) <u>Hair</u> (Middle) <u>Durant</u> (Last)		4. DATE OF DEATH <u>4</u> (Month) <u>30</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 4 1881</u> 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	9. AGE last birthday <u>69</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Shawneetown Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Benjamin M. Hair</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Ridgway</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Mrs Catherine Heap 5608 Edgemoor Lane</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary thrombosis

INTERVAL BETWEEN ONSET AND DEATH

15 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive - arteriosclerotic heart disease with chronic failure15 years.(c) Arterial thrombosis with left bundle branch block9 months.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify) noPLACE (Home, farm, factory, street, OF office hldg., etc.) —(CITY OR TOWN) —(COUNTY) —(STATE) —TIME (Month) (Day) (Year) (Hour) OF INJURY — m.INJURY OCCURRED While at Work ☐ Not While At work ☐HOW DID INJURY OCCUR? —22. I hereby certify that I attended the deceased from March 12, 1948, to April 30, 1951, that I last saw the deceasedalive on April 30, 1951, and that death occurred at 11:45 A.M., from the causes and on the date stated above.SIGNATURE Bertman F. Schaefer, M.D.

(Degree or title)

ADDRESS 1801 X. St. N.W. Wash. D.C.DATE SIGNED 4/30/5123. BURIAL, CREMATION REMOVAL. (Specify) BurialDATE THEREOF 5-3-51NAME OF CEMETERY OR CREMATORY Graceland Cem.LOCATION (City, town, or county) Chicago Illinois

(State)

DATE REC'D BY LOCAL REG. 4/30/51REGISTRAR'S SIGNATURE Bessie M. Thompson24. FUNERAL DIRECTOR The S.H. Nino Co.ADDRESS 2901-14 St. N.W.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MAY 2 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 218

3892

1. PLACE OF DEATH COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>OLNEY</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>THE MONTGOMERY COUNTY GENERAL HOSPITAL INC.</u>		STREET ADDRESS <u>R# 3</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>BABY Kathleen Ann</u>		4. DATE OF DEATH (Month) <u>APRIL</u> (Day) <u>21</u> (Year) <u>1951</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>3/28/51</u>	
9. AGE last birthday <u>—</u> yrs.		10. If under 1 year Months <u>—</u> Days <u>24</u> Hours <u>3</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOSEPH H. EDENS</u>		14. MOTHER'S MAIDEN NAME <u>OVIDA MOORE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Joseph H. Edens, Rockville, Md. 3</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Prematurity (32 wks gestation)</u>		<u>24 days</u>
Antecedent cause(s) (b) <u>776X Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		
(c) <u>159</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>
(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 3/28, 1951, to 4/21, 1951, that I last saw the deceased alive on 4/21, 1951, and that death occurred at 11 PM, from the causes and on the date stated above.

SIGNATURE <u>[Signature]</u>	(Degree or title) <u>MD</u>	ADDRESS <u>Sandy Spring Md.</u>	DATE SIGNED <u>4/21/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 28, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rockville Md</u>	LOCATION (City, town, or county) (State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>4/23/51</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>[Signature]</u>	ADDRESS <u>Rockville Md</u>

2-0-3-28-1-35-8-40-3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. This certificate is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

APR 25 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

3893

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Virginia</u> COUNTY <u>Accomack</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Oak Hall</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>none</u>	
3. NAME OF DECEASED (First) <u>Cloyd</u> (Middle) <u>Gene</u> (Last) <u>EICHELBERGER</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>15</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Apr. 13, 1951</u>
9. AGE last birthday <u>00</u> yrs. <u>00</u> months <u>02</u> days		10. IF under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - -</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Wilmer G. EICHELBERGER</u>		14. MOTHER'S MAIDEN NAME <u>Marion SHAFFER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>- - - -</u>		16. SOCIAL SECURITY NO. <u>- - - -</u>	
17. INFORMANT AND ADDRESS <u>Father: Wilmer G. EICHELBERGER</u>			

18. MEDICAL CERTIFICATION same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Congenital Heart Disease

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Apr. 14, 1951, to Apr. 15, 1951, that I last saw the deceased

alive on Apr. 15, 1951, and that death occurred at 7:28 A.m., from the causes and on the date stated above.

SIGNATURE E. W. Sederstrom (Degree or title) ADDRESS U.S. NAVAL HOSPITAL DATE SIGNED April 15, 1951

23. BURIAL, CREMATION REMOVAL (Specify) Removal DATE THEREOF Apr 15, 1951 NAME OF CEMETERY OR CREMATORY Everett Cemetery LOCATION (City, town, or county) Everett, Penn. (State)

DATE REC'D BY LOCAL REG Apr 15, 1951 REGISTRAR'S SIGNATURE Edell Whittington 24. FUNERAL DIRECTOR R. A. Pumphrey ADDRESS 7557 Wisconsin Avenue, Bethesda, Maryland.

904131990990

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 17 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

3894

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>20 Montgomery Ave</u>		STREET ADDRESS (If rural, give location) <u>20 Montgomery Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Maye Ellen Eselman</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>4</u> (Year) <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>Mar 23 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
13. FATHER'S NAME <u>Henry M. Fadden</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Sanders</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>-</u>	
		17. INFORMANT <u>Edgar Eselman</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Cerebral Hemorrhage</u>	<u>18 days</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Gen. Arteriosclerosis 1 day preterminal</u>	<u>15 yrs</u>
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/16/36, to 4/4/51, that I last saw the deceased alive on 4/3/51, 1951, and that death occurred at 6 P.m., from the causes and on the date stated above.

SIGNATURE <u>Edward H. Moore</u>	(Degree or title)	ADDRESS <u>28 Carroll Ave Takoma Park Md</u>	DATE SIGNED <u>4/4/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 6, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Urbington Hall Cem</u>	LOCATION (City, town, or county) (State) <u>Urbington, Va</u>
DATE REC'D BY LOCAL REG. <u>4-4-51</u>	REGISTRAR'S SIGNATURE <u>J. Melvin Dodd</u>	24. FUNERAL DIRECTOR <u>Edgar Eselman</u>	ADDRESS <u>254 Carroll St. Takoma Park Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

1951

U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

3895

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San Hosp</u>		STREET ADDRESS (If rural, give location) <u>6005 Gude Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Orlo</u> (First) <u>Henry</u> (Middle) <u>Frost</u> (Last)	4. DATE OF DEATH <u>4</u> (Month) <u>7</u> (Day) <u>1957</u> (Year)		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11-30-85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Court reporter</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>65</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>Charles A. Frost</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Hospital records</u>		14. MOTHER'S MAIDEN NAME <u>Jeannette Griffin</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

19a. DATE OF OPERATION <u>2/2/49</u>	19b. MAJOR FINDINGS OF OPERATION <u>Death Upper Resp. Infection (Virus)</u>
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21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accidental</u>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>	(CITY OR TOWN) <u>Takoma Park Md</u>	(COUNTY) <u>Montgomery</u>	(STATE) <u>Md</u>
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TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12/10/46</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>4/7/51</u>
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22. I hereby certify that I attended the deceased from <u>12/10/46</u> , 19 <u>46</u> , to <u>4/7/51</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>4/6/51</u> , 19 <u>51</u> , and that death occurred at <u>12:30</u> p.m., from the causes and on the date stated above.
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SIGNATURE <u>Dr. Joseph P. ...</u>	ADDRESS <u>Washington D.C.</u>	DATE SIGNED <u>4/7/51</u>
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23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4-10-51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cem</u>	LOCATION (City, town, or county) <u>St. Joseph's</u>	(State) <u>Md</u>
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DATE REC'D BY LOCAL REG. <u>4-7-51</u>	REGISTRAR'S SIGNATURE <u>J. ...</u>	24. FUNERAL DIRECTOR <u>Frank Joy</u>	ADDRESS <u>Washington D.C.</u>
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25. DATE OF DEATH <u>4-7-51</u>	26. DATE OF BIRTH <u>11-30-85</u>	27. DATE OF DEATH <u>4-7-51</u>	28. DATE OF BIRTH <u>11-30-85</u>
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29. DATE OF DEATH <u>4-7-51</u>	30. DATE OF BIRTH <u>11-30-85</u>	31. DATE OF DEATH <u>4-7-51</u>	32. DATE OF BIRTH <u>11-30-85</u>
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33. DATE OF DEATH <u>4-7-51</u>	34. DATE OF BIRTH <u>11-30-85</u>	35. DATE OF DEATH <u>4-7-51</u>	36. DATE OF BIRTH <u>11-30-85</u>
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37. DATE OF DEATH <u>4-7-51</u>	38. DATE OF BIRTH <u>11-30-85</u>	39. DATE OF DEATH <u>4-7-51</u>	40. DATE OF BIRTH <u>11-30-85</u>
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41. DATE OF DEATH <u>4-7-51</u>	42. DATE OF BIRTH <u>11-30-85</u>	43. DATE OF DEATH <u>4-7-51</u>	44. DATE OF BIRTH <u>11-30-85</u>
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45. DATE OF DEATH <u>4-7-51</u>	46. DATE OF BIRTH <u>11-30-85</u>	47. DATE OF DEATH <u>4-7-51</u>	48. DATE OF BIRTH <u>11-30-85</u>
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49. DATE OF DEATH <u>4-7-51</u>	50. DATE OF BIRTH <u>11-30-85</u>	51. DATE OF DEATH <u>4-7-51</u>	52. DATE OF BIRTH <u>11-30-85</u>
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53. DATE OF DEATH <u>4-7-51</u>	54. DATE OF BIRTH <u>11-30-85</u>	55. DATE OF DEATH <u>4-7-51</u>	56. DATE OF BIRTH <u>11-30-85</u>
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57. DATE OF DEATH <u>4-7-51</u>	58. DATE OF BIRTH <u>11-30-85</u>	59. DATE OF DEATH <u>4-7-51</u>	60. DATE OF BIRTH <u>11-30-85</u>
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61. DATE OF DEATH <u>4-7-51</u>	62. DATE OF BIRTH <u>11-30-85</u>	63. DATE OF DEATH <u>4-7-51</u>	64. DATE OF BIRTH <u>11-30-85</u>
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65. DATE OF DEATH <u>4-7-51</u>	66. DATE OF BIRTH <u>11-30-85</u>	67. DATE OF DEATH <u>4-7-51</u>	68. DATE OF BIRTH <u>11-30-85</u>
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69. DATE OF DEATH <u>4-7-51</u>	70. DATE OF BIRTH <u>11-30-85</u>	71. DATE OF DEATH <u>4-7-51</u>	72. DATE OF BIRTH <u>11-30-85</u>
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73. DATE OF DEATH <u>4-7-51</u>	74. DATE OF BIRTH <u>11-30-85</u>	75. DATE OF DEATH <u>4-7-51</u>	76. DATE OF BIRTH <u>11-30-85</u>
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77. DATE OF DEATH <u>4-7-51</u>	78. DATE OF BIRTH <u>11-30-85</u>	79. DATE OF DEATH <u>4-7-51</u>	80. DATE OF BIRTH <u>11-30-85</u>
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

250936

RECEIVED
APR 12 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

3896

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Montgomery</u> COUNTY <u>Maryland</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1811 Arcola Ave.</u>		STREET ADDRESS (If rural, give location) <u>1811 Arcola Avenue.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Maria</u> <u>Fry</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 24</u> <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>11-5-92</u>
10a. USUAL OCCUPATION (Give kind of work done in most of working life even if retired) <u>Home maker.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>58</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Lott</u>		14. MOTHER'S MAIDEN NAME <u>Susanna S. Lott</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mr. Wilfred C. Fry, 1811 Arcola Ave.</u>		<u>Silver Spring, Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Generalized Abdominal Carcinomatosis</u>		<u>1 year</u>
175X Antecedent cause(s)	(b) <u>Carcinoma Both Ovaries</u>		<u>1 year</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Cachexia, Ascites</u>		<u>3 months</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>4-24-50</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma Both Ovaries</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>none</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>	INJURY OCCURRED <u>none</u> m. <u>none</u> Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1-26, 1951, to 4-24, 1951, that I last saw the deceased alive on 4-24, 1951, and that death occurred at 5:00 p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W. E. Shoemaker M.D. 8005 Woodbury Dr. Silver Spring, Md. 4/24/51

23. BURIAL, CREMATION REMOVAL (Specify) Temp. Entombment	DATE <u>4/28/51</u>	NAME OF CEMETERY OR CREMATORY <u>Warner E. Pumphrey Funeral Home</u>	LOCATION (City, town, or county) (State) <u>Silver Spring, Montgomery Co. Md.</u>
DATE REC'D BY LOCAL REG. <u>Apr 27/51</u>	REGISTRAR'S SIGNATURE <u>Francis C. Otter</u>	24. FUNERAL DIRECTOR <u>Warner E. Pumphrey</u>	ADDRESS <u>8434 Ga. Ave., Silver Spring Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

MAY 11 1961

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>311 W. Mount Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Buell</u> (Middle) <u>MONNIS</u> (Last) <u>GARDNER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 13</u> <u>1951</u>	
5. SEX <u>M/F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 12, 1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher - High</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Real estate</u>	9. AGE last birthday <u>53</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>New York</u>
13. FATHER'S NAME <u>John Gardner</u>	14. MOTHER'S MAIDEN NAME <u>Guthrie</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	16. SOCIAL SECURITY NO. <u>Wanted</u>	17. INFORMANT AND ADDRESS <u>Margaret Gardner, wife, Rockville</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>congestive Heart Failure -</u>			<u>2 days</u>
Antecedent cause(s) (b) <u>Rheumatic Heart Disease -</u>			<u>38 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>myocardial infarction</u>			<u>6 yrs -</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not While At work <input type="checkbox"/> At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from....., 19 <u>48</u> , to <u>April 13</u> , 19 <u>51</u> ., that I last saw the deceased alive on..... <u>4/13</u> ., 19....., and that death occurred at..... <u>6:15 P</u> ..m., from the causes and on the date stated above.			
SIGNATURE <u>Walter Welch, M.D.</u>		DATE SIGNED <u>Rockville, Maryland 4/15/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>14 Apr. 1951</u>	<u>Parkwood Cemetery</u>	<u>Baltimore Md.</u>
DATE REC'D BY LOCAL REG. <u>4-16-51</u>	REGISTRAR'S SIGNATURE <u>Helen L. Ehrenfeld</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	ADDRESS <u>Baltimore, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3897

476736

RECEIVED
APR 17 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

3898

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5420 Glenwood Ave.</u>		STREET ADDRESS (If rural, give location) <u>5420 Glenwood Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>Edward</u> (Middle) <u>Gilmore</u> (Last)	4. DATE OF DEATH <u>Apr</u> <u>11</u> <u>1951</u>	5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>2 March 1897</u>	9. AGE last birthday <u>54</u> yrs. <u>1</u> Months <u>1</u> Days	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dept. of Defense</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>	11. BIRTHPLACE (State or foreign country) <u>Chicago, Ill.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert N. Gilmore</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W.I.</u>		16. SOCIAL SECURITY No. <u>220-26-2567</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Wm. ED Gilmore - Same</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary occlusion</u>		<u>sudden</u>
94a Antecedent cause(s) (b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last		<u>death.</u>
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE <u>Frank J. Broschack M.D. Gaithersburg Md</u>	DATE SIGNED <u>4-11-51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>13 Apr 1951</u>
NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>
DATE REC'D BY LOCAL REG. <u>4-16-51</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 17 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

3899

Evidence for addition
in 21 shown on:

CERTIFICATE OF DEATH

HAM No. G 1-2 APR 18 1951 FOR MEDICAL EXAMINERS

Reg. Dist. No. 223

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>P. G.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Takoma Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Sanatorium & Hosp</u>		STREET ADDRESS (If rural, give location) <u>707 Lermonshire Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Jeffrey</u> (Middle)		4. DATE (Month) (Day) (Year) OF DEATH <u>6-1-51</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	9. AGE last birthday <u>2-28-48</u> 3 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Wash DC</u>
13. FATHER'S NAME <u>Clayton N. Gladd</u>		14. MOTHER'S MAIDEN NAME <u>Ingram, Beverly</u>	
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT AND ADDRESS <u>mother</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
8/25 Immediate cause (a) <u>Shock due to concussion and</u>		1 hr.
170c Antecedent cause(s) (b) <u>hemorrhage</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>separation of rt parietal and frontal suture (accidental)</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg, etc.) INJURY <u>street</u>	(CITY OR TOWN) (COUNTY) (STATE) <u>Takoma Park P. G. md</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Apr 5-51 10:45 a.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>struck by auto (4/17/51 aka)</u>

22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Frank J. Brockhart M.D.</u>		DATE SIGNED <u>4-5-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>4-7-51</u>		NAME OF CEMETERY OR CREMATORY <u>Bedar Hill</u>	
DATE REC'D BY LOCAL REG. <u>4-5-51</u>		24. FUNERAL DIRECTOR <u>Wm Lee Sons Co.</u>	
REGISTRAR'S SIGNATURE <u>J. M. Ladd</u>		ADDRESS <u>300 4th St N.E. Washington 2, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. ALKA

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RECEIVED
JUN 11 1951
U. S. AIR FORCE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3900

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>807 Islington St.</u>		STREET ADDRESS (If rural, give location) <u>807 Islington Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Harry</u>	(Middle) <u>P.</u>	(Last) <u>Godwin</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 8, 1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber -- worked for:</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Morris J. Colbert Co.</u>	9. AGE last birthday <u>48</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>George W. Godwin</u>		14. MOTHER'S MAIDEN NAME <u>Johanna Palmer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-03-6043</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Anna Maria Godwin, 801 Islington St.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

161x Immediate cause (a) Carcinoma of the bladder. about 1 yr.
52b Antecedent cause(s) (b) with spread of Ca throughout the abdomen
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>3/21/51</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of bladder & Intestines.</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/4/51, 1951, to 4/15/51, 1951, that I last saw the deceased alive on 4/13/51, 1951, and that death occurred at 9:35 P.M., from the causes and on the date stated above.

SIGNATURE Walter K. Angervine, M.D. (Degree or title) ADDRESS 6300-13th St. N.W., Wash. D.C. DATE SIGNED 4/15/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE WHEREOF <u>4/19/51</u>	NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	LOCATION (City, town, or county) (State) <u>Prince Geo. County Md.</u>
DATE REC'D BY LOCAL REG. <u>April 18/51</u>	REGISTRAR'S SIGNATURE <u>Frances Potter</u>	24. FUNERAL DIRECTOR <u>Warren L. Pumphrey</u>	ADDRESS <u>8434 Ga. Ave., Silver Spring Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 20 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

3901

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>310 Essex St.</u>	
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>Griffith</u> (Middle) <u>G</u> (Last)		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>12</u> (Year) <u>1951</u>	
5. SEX <u>MALE</u> <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 9, 1968</u>
9. AGE last birthday <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. GARAGE OWNER</u>	
11. BIRTHPLACE (State or foreign country) <u>KINGSTON, CANADA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAMUEL GRIFFITH, Samuel</u>		14. MOTHER'S MAIDEN NAME <u>SUZANNE McCoy</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>MRS. HAROLD F. TANKE</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Respiratory Failure</u>		<u>1 hour</u>
Antecedent cause(s) (b) <u>Cerebral Hemorrhage</u>		<u>8 days</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertension, Advanced Arteriosclerosis</u>		<u>10 years</u>

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from November 50, 1950, to April 12, 1951, that I last saw the deceased alive on April 12, 1951, and that death occurred at 10:40 A.M., from the causes and on the date stated above.

SIGNATURE Frank Y. Jagger Jr. M.D. (Degree or title) ADDRESS 5701 Wisconsin Ave. Chevy Chase, Md. DATE SIGNED 4/12/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>	DATE THEREOF <u>4-13-51</u>	NAME OF CEMETERY OR CREMATORY <u>Croftwood - Michigan</u>	LOCATION (City, town, or county) (State) <u>Sanilac County, Michigan</u>
DATE REC'D BY LOCAL REG. <u>April 13, 1951</u>	REGISTRAR'S SIGNATURE <u>Frances Potter</u>	24. FUNERAL DIRECTOR ADDRESS <u>Frank A. Singler, Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5907 Wls.

RECEIVED

APR 16 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH - COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium - Hospital</u>		STREET ADDRESS (If rural, give location) <u>901 Flower Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Joseph</u> (Middle) <u>Franklin</u> (Last) <u>Haigh</u>	4. DATE OF DEATH (Month) <u>4</u> (Day) <u>26</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>8-23-94</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk, Vets Ad.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	9. AGE last birthday <u>56</u> yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Le Rausville, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John F. Haigh</u>		14. MOTHER'S MAIDEN NAME <u>Ella Hill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral hemorrhage, rt. temporal, parietal lobes

INTERVAL BETWEEN ONSET AND DEATH

8 daysAntecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last(b) Myocardial hypertrophy with arrhythmiaYears(c) Hypertension atherosclerotic, bilateral11 1/2 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death

1. Hypertrophy of adrenal, bilateral
2. Diverticulitis lower sigmoidUnknown

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Nov. 13, 1939 to Apr. 26, 1951, that I last saw the deceased alive on Apr. 25, 1951, and that death occurred at 1 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Wallace K. Mook M.D.Takoma Park, Md.4-26-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial & Trans.</u>	DATE THEREOF <u>5/1/51</u>	NAME OF CEMETERY OR CREMATORY <u>Tioga Point Cemetery</u>	LOCATION (City, town, or county) (State) <u>Athens, Bradford Co. Pa.</u>
DATE REC'D BY LOCAL REG. <u>4-28-51</u>	REGISTRAR'S SIGNATURE <u>J. Nelson Dodd</u>	24. FUNERAL DIRECTOR <u>Warwick Pumphrey</u>	ADDRESS <u>8434 Ga. Ave., Silver Spring Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

MAY 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

3903

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Fairthursburg Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Fairthursburg Md</u>	
TOWN <u>Fairthursburg</u>		TOWN <u>Fairthursburg Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>24 West Montgomery Co Hospital</u>		STREET ADDRESS (If rural, give location) <u>Cherry Maryland</u>	
3. NAME OF DECEASED (Type or Print) <u>JOHNNIE</u> (First) <u>W</u> (Middle) <u>HALL</u> (Last)	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>10</u> (Year) <u>1951</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 17-1868</u>
9. AGE last birthday <u>82</u> yrs.	If under 1 year Months Days Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>on Farm</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>on Farm</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>William Hall</u>	
14. MOTHER'S MAIDEN NAME <u>Susan</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY No. <u>no</u>		17. INFORMANT AND ADDRESS <u>Lam Prather Fairthursburg</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>degenerative Heart Disease</u>		<u>Not</u>	
Antecedent cause(s) (b) <u>manifested by congestive heart failure, 12 yr old heart block.</u>		<u>known</u>	
(c) <u>93d</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>HOMICIDE</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>April 3, 1951</u> , to <u>April 10, 1951</u> , that I last saw the deceased alive on <u>April 10, 1951</u> , and that death occurred at <u>11:45 p.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Jack Schumacher M.D.</u> (Degree or title)		ADDRESS <u>Fairthursburg, Md</u> DATE SIGNED <u>Apr. 10, 1951</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 13-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Brook Grove</u>	LOCATION (City, town, or county) (State) <u>Montgomery Co Md</u>
DATE REC'D BY LOCAL REG. <u>4-13-51</u>	REGISTRAR'S SIGNATURE <u>Gertrude B Lawler</u>	24. FUNERAL DIRECTOR <u>Ray W Barber</u>	ADDRESS <u>Fairthursburg Md</u>

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RECEIVED

APR 17 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 212

3904

1. PLACE OF DEATH COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sellman, Md</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sellman, Md</u> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) <u>Alfred</u> (Middle) <u>Harper</u> (Last) <u>Harper</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>25</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec. 22, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	9. AGE last birthday <u>77</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George C. Harper</u>		14. MOTHER'S MAIDEN NAME <u>Rose Lee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. <u>210-11-1111</u>	
17. INFORMANT <u>Joseph Harper</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>442X</u> <u>131a</u> <u>Uremia</u>		<u>30 hours</u>
(b) Antecedent cause(s) <u>Hypertensive Cardiovascular Renal Disease</u>		<u>5 years</u>
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>20 Apr.</u> , 1957, to <u>25 Apr.</u> , 1957, that I last saw the deceased alive on <u>25 Apr.</u> , 1957, and that death occurred at <u>4:55 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Jordan M. Smith</u> (Degree or title) <u>M.D.</u>		ADDRESS <u>Barnesville, Md</u> DATE SIGNED <u>25 Apr 57</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/29/57</u>	NAME OF CEMETERY OR CREMATORY <u>Protestant</u>	LOCATION (City, town, or county) (State) <u>Protestant, Md</u>
DATE REC'D BY LOCAL REG. <u>Apr. 28, 1957</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md</u>	

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

820105

REC-110

MAY 2 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3905

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE District of Columbia COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural, give location) 4200 38th Street, N.W.	
3. NAME OF DECEASED (First) Helen (Middle) Baxter (Last) HARPER		4. DATE OF DEATH (Month) April (Day) 4 (Year) 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH May 29, 1901
9. AGE last birthday 49 yrs. 10 months 08 days		10. If under 1 year If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME William BAXTER		14. MOTHER'S MAIDEN NAME Kate MAC GILL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) - - - - -		16. SOCIAL SECURITY No. - - - - -	
17. INFORMANT AND ADDRESS Husband: John HARPER			

18. MEDICAL CERTIFICATION Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **CARCINOMA, PANCREAS**

INTERVAL BETWEEN ONSET AND DEATH

Indef.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Mar 13**, 19 **51**, to **Apr 4**, 19 **51**, that I last saw the deceasedalive on **Apr 4**, 19 **51** and that death occurred at **5:15 P.m.**, from the causes and on the date stated above.SIGNATURE **S. R. Mills, Jr.** (Degree or title)

ADDRESS

DATE SIGNED

S. R. MILLS, Jr., LTJG, MC, USN U.S. NAVAL HOSPITAL April 5, 1951

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Apr 6, 1951	NAME OF CEMETERY OR CREMATORY Arlington National	LOCATION (City, town, or county) Arlington, Virginia	(State)
DATE REC'D BY LOCAL REG. Apr 5, 1951	REGISTRAR'S SIGNATURE Edith Whittington	24. FUNERAL DIRECTOR R. A. Pumphrey	ADDRESS 7557 Wisconsin Avenue, Bethesda, Maryland.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 9 1951
BUREAU 7-8

NEW YORK, NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>District of Columbia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium + Hospital</u>		STREET ADDRESS (If rural, give location) <u>1500 Decatur St. N.W.</u> ✓	
3. NAME OF DECEASED (Type or Print) <u>Lena</u> (First) <u>Elizabeth</u> (Middle) <u>Harris</u> (Last)		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>27</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>10-31-72</u>
9. AGE last birthday <u>78</u> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis F. Wolfes</u>		14. MOTHER'S MAIDEN NAME <u>Fannie E. Mac Lea</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Hospital Records.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

181X Immediate cause (a) <u>Gastric hemorrhage - Sec. Arteria</u>	INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
52X Antecedent cause(s) (b) <u>Carcinoma bladder</u>	<u>3 months +</u>
(c)	

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 17, 1951, to April 27, 1951, that I last saw the deceased alive on April 26, 1951, and that death occurred at 4:20 a.m., from the causes and on the date stated above.

SIGNATURE <u>John A. Brown</u>	DATE THEREOF <u>4-30-51</u>	NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	LOCATION (City, town, or county) <u>Washington D.C.</u> (State) <u>D.C.</u>
DATE REC'D BY LOCAL REG. <u>4-27-51</u>	REGISTRAR'S SIGNATURE <u>John A. Brown</u>	24. FUNERAL DIRECTOR <u>The S. A. Hines Co. Washington D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MAY 1 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

3907

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Ohio</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Youngstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Alta Vista Rest Home</u>		STREET ADDRESS (If rural, give location) <u>224 W. Dennick St.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Francis E. Hearn</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 14 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>5 Sept. 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President of Hearn Paper Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>79</u> yrs.
13. FATHER'S NAME <u>Thomas Hearn</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
16. SOCIAL SECURITY No.		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>6920 A Fairfax Rd. Mrs Ralph L. Ingram Bethesda, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cardiac decompensation</u>			<u>48 hr.</u>
Antecedent cause(s) (b) <u>Infant Rtx of Right lung from Embolism</u>			<u>5 days</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertensive, Cardiovascular Disease severe - Generalized Arteriosclerosis - Epileptic form convulsions from Arteriosclerosis</u>			<u>10 yr.?</u> <u>20 yr.?</u> <u>3 yr.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Sept., 1947, to 14 April, 1951, that I last saw the deceased alive on 13 April, 1951, and that death occurred at 2:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial-transit</u>	DATE <u>4/14/51</u>	NAME OF CEMETERY OR CREMATORY <u>Tod Memorial</u>	LOCATION (City, town, or county) <u>Youngstown, Ohio</u>	(State)
DATE REC'D BY LOCAL REG. <u>4-16-51</u>	REGISTRAR'S SIGNATURE <u>Helen J. Eckerfeldt</u>	24. FUNERAL DIRECTOR <u>Robert J. Humphrey</u>	ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

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APR 17 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

3908

1. PLACE OF DEATH - COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lakema Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lakema Park</u>	
TOWN <u>Lakema Park</u>		TOWN <u>Lakema Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San. & Hospital</u>		STREET ADDRESS (If rural, give location) <u>94 Davis Ave.</u>	
3. NAME OF DECEASED (First) <u>Onic</u>	(Middle) <u>-</u>	(Last) <u>Henderson</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>29</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>1-19-68</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>83</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James W. Howard</u>		14. MOTHER'S MAIDEN NAME <u>Tinsic Narramore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. E. Backus, 425 Whittier St. S.W. DC</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Thrombosis</u>		<u>days</u>	
Antecedent cause(s) (b) <u>Arteriosclerotic Cardiovascular Disease</u>		<u>years</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Terminal Uremia & Pyelonephritis</u>		<u>days</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes Mellitus</u>		<u>years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		(CITY OR TOWN) (COUNTY) (STATE)	
22. I hereby certify that I attended the deceased from <u>Jan 10, 1946</u> , to <u>April 29, 1951</u> , that I last saw the deceased alive on <u>4-29</u> , 1951, and that death occurred at <u>4:20 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Dr. H. K. Made</u>		ADDRESS <u>Lakema Park 12, Md.</u>	
DATE SIGNED <u>4-29-51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 1, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>In. Geo. County, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>4-29-51</u>		REGISTRAR'S SIGNATURE <u>J. Arthur Dalton</u>	
24. FUNERAL DIRECTOR <u>J. Arthur Dalton</u>		ADDRESS <u>254 Central St. SW</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 1 1951

BUREAU
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3909

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ROCKVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ROCKVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>908 VIKERS MILK RD.</u>	
3. NAME OF DECEASED (Type or Print) <u>WILKINSON</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Unmarried</u>	8. DATE OF BIRTH <u>3-4-1857</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. FATHER'S NAME <u>William H. Wootton</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		17. INFORMANT AND ADDRESS <u>John A. Higgins, 1500 East</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Arteriosclerosis, myocardial failure</u>		Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>450.0</u> <u>97</u> { <u>Diabetic cataracts, with blindness</u> <u>Scailty</u>	<u>Stroke</u>
Antecedent cause(s) (b)			<u>10 years</u>
(c)			<u>-</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1940, 19....., to April 17, 1951, that I last saw the deceased alive on April 15, 1951, and that death occurred at 3:55 A.M., from the causes and on the date stated above.

SIGNATURE Wm. H. Wootton, M.D. - Rockville, Md. ADDRESS 4/17/51.

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Apr. 19, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>	LOCATION (City, town, or county) <u>Balto., Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>4/19/51</u>	REGISTRAR'S SIGNATURE <u>Helen S. Eckenfelder</u>	24. FUNERAL DIRECTOR <u>W W Chambers Co 1400 Chapin St Wash. D.C.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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APR 20 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

3910

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brookville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brookville</u>	
TOWN <u>Brookville</u> LENGTH OF STAY (In this place) <u>life</u>		TOWN <u>Brookville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. #1</u>		STREET ADDRESS (If rural, give location) <u>R.F.D. #1</u>	
3. NAME OF DECEASED (First) <u>Lloyd</u> (Middle) <u>Walter</u> (Last) <u>Holland</u>		4. DATE OF DEATH (Month) <u>Apr</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>15 Nov 1869</u>
9. AGE last birthday <u>81</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
13. FATHER'S NAME <u>James Thomas Holland</u>		14. MOTHER'S MAIDEN NAME <u>Alice Finthrum</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Sgt. H. Wood - Brookville, Ind.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420. Immediate cause (a) <u>Coronary occlusion</u>			<u>Found dead in bed.</u>
Antecedent cause(s) (b) <u>94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Frank J. Broschart M.D.</u>		DATE SIGNED <u>4-1-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/3/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>
DATE REC'D BY LOCAL REG. <u>4-1-51</u>		REGISTRAR'S SIGNATURE <u>Estimote - Law</u>	LOCATION (City, town, or county) <u>Rockville, Ind.</u>
		24. FUNERAL DIRECTOR <u>Robert A. Humphrey - Bethel, Ind.</u>	ADDRESS <u>100105</u>



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

3911

Reg. Dist. No. 215

1. PLACE OF DEATH CITY Montgomery OR MARYLAND TOWN Bethesda, Rural		2. USUAL RESIDENCE (HOME) OF DECEASED STATE District of Columbia CITY (If outside corporate limits, write RURAL and give nearest town) Washington OR Washington TOWN Washington STREET ADDRESS (If rural, give location) 1916 West Virginia Ave., NE	
3. NAME OF DECEASED (Type or Print) Garland (First) Herbert (Middle) HUDSON (Last)		4. DATE OF DEATH April 7, 19 51 (Month) (Day) (Year)	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 7-12-87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book Binder		10b. KIND OF BUSINESS OR INDUSTRY Govt P.O.	9. AGE last birthday 63 yrs. 8 Months 26 Days (If under 1 year) (If under 24 hrs)
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Frank HUDSON		14. MOTHER'S MAIDEN NAME Betty GARLAND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) YES (If yes, give war or dates of service) 1918-19		16. SOCIAL SECURITY No. 1918-19	
17. INFORMANT AND ADDRESS Wash., D.C. Wife: Ora HUDSON 1916 W. Va. Ave NE			

18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) pulmonary embolism (massive)		INTERVAL BETWEEN ONSET AND DEATH minutes	
Antecedent cause(s) (b) Bilateral		Death death.	
11a. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING THE UNDERLYING CAUSE LAST (c) Old unhealed fracture of left tibia			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 2 yrs.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE Frank J. Broschart		ADDRESS Gaithersburg, Maryland	
DATE SIGNED April 8, 1951		DATE SIGNED April 8, 1951	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Apr. 12, 1951	
NAME OF CEMETERY OR CREMATORY Arlington National		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REG. Apr 8, 1951		REGISTRAR'S SIGNATURE Edith Whittington	
24. FUNERAL DIRECTOR W.E. JARVIS		ADDRESS 1432 U St. NW Wash., D.C.	

J.W.H.

502459

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 10 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

3912

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital		STREET ADDRESS (If rural, give location) 1803 Cody Drive	
3. NAME OF DECEASED (Type or Print) (First) Jeffrey (Middle) Wyatt (Last) HUGHES		4. DATE OF DEATH (Month) April (Day) 2 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Mar 31, 1951
9. AGE last birthday 00 yrs. 00 Months 03 Days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME James T. HUGHES		14. MOTHER'S MAIDEN NAME Barbara QUANDT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT AND ADDRESS Father: James T. HUGHES			

18. MEDICAL CERTIFICATION Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Mar 31, 1951** to **Apr 2, 1951**, that I last saw the deceased alive on **Apr 2, 1951**, and that death occurred at **7:55 P.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

A. GEDAROVICH, LT, MC, USN.**U.S. NAVAL HOSPITAL****April 3, 1951**

23. BURIAL, CREMATION REMOVAL (Specify) Disposition	DATE THEREOF Apr 3, 1951	NAME OF CEMETERY OR CREMATORY U.S. Naval Medical Sch., Bethesda, Maryland	LOCATION (City, town, or county) Bethesda, Maryland	(State)
DATE REC'D BY LOCAL REGISTRAR Apr 3, 1951	REGISTRAR'S SIGNATURE Edal Whittington	24. FUNERAL DIRECTOR None	ADDRESS	

2-0-3-31-1-34-4-33-1.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES OF AMERICA

RECEIVED
APR 6 1951
BUREAU Y. B.

RECEIVED APR 6 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3913 223

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
TOWN <u>Takoma Park</u>		TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium & Hospital</u>		STREET ADDRESS (If rural, give location) <u>411 Ellsworth Drive</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Harrie</u> (Middle) <u>XXXXXX</u> (Last) <u>Chase</u>	4. DATE OF DEATH	(Month) <u>4</u> (Day) <u>29</u> (Year) <u>1951</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>2-19-67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	9. AGE last birthday <u>84</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Staten Co. - N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Baker Chase</u>		14. MOTHER'S MAIDEN NAME <u>Mary Delia Surten</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mr. Clifford W. Hurley</u>		18. MEDICAL CERTIFICATION <u>Hospital Records & 411 Ellsworth Dr. Silver Spring Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Myocardial InfarctionAntecedent cause(s) (b) Arterio-sclerotic Heart DiseaseDiseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) PeritonitisII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.19a. DATE OF OPERATION none 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 8-12, 1947, to 4-29, 1951, that I last saw the deceasedalive on 4-28, 1951, and that death occurred at 3:20 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Dean H. Harding M.D. 113 Carroll St NW Wash DC

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Trans. & Burial</u>	<u>5/3/51</u>	<u>Woodlawn Cemetery</u>	<u>Chemung County,</u>	<u>N.Y.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5/11/51</u>	<u>G. William Dodd</u>	<u>Warner & Pumphrey</u>	<u>8434 Ga. Ave., Silver Spring Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

MAY 4 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

3914

1. PLACE OF DEATH COUNTY <u>Montgomery Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE _____ COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lakona Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u>	
TOWN <u>Lakona Park</u>		TOWN <u>Washington DC</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>716 Hudson St</u>		STREET ADDRESS <u>1730 M St NW</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>MARY</u> (Middle) <u>ELLA</u> (Last) <u>HUYCK</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>24</u> (Year) <u>1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>unmarried</u>	8. DATE OF BIRTH <u>Sept 17, 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>don't know</u>	11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>
13. FATHER'S NAME <u>William Oliver Bruff</u>		14. MOTHER'S MAIDEN NAME <u>Ella Chandler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT AND ADDRESS <u>John Bruff Lakona Park Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) myocardial infarction due to coronary

Antecedent cause(s)

(b) Sen. arteriosclerosis with arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) heart disease(c) Re. sided hemi-paralysis

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) <u>OF INJURY</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Nov 1948, to 4-24, 1951, that I last saw the deceased alive on 4-20, 1951, and that death occurred at 1:40 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/26/51</u>	NAME OF CEMETERY OR CREMATORY <u>mt Olivet</u>	LOCATION (City, town, or county) <u>Washington DC</u>	(State) <u>DC</u>
DATE REC'D BY LOCAL REG. <u>4/26/51</u>	REGISTRAR'S SIGNATURE <u>J. William Bruff</u>	24. FUNERAL DIRECTOR <u>F. Gaschione</u>	ADDRESS <u>Hyattsville Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

3915

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Alton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS <u>none</u> (If rural, give location)	
3. NAME OF DECEASED (First) <u>Robert</u> (Middle) <u>Lee</u> (Last) <u>IRWIN</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>13</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug 6, 1891</u>
9. AGE last birthday <u>59</u> yrs. <u>08</u> mos. <u>08</u> days		10. If under 1 year <u>08</u> mos. <u>08</u> days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Gov't</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Matthew IRWIN</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth ROBEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY No. <u>- - - - -</u>	
17. INFORMANT AND ADDRESS <u>Brother: John S. IRWIN</u>		18. MEDICAL CERTIFICATION <u>Same as item # 2</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Ventricular fibrillation</u>		<u>Immediate</u>	
Antecedent cause(s) (b) <u>Myocardial infarction</u>		<u>2 years</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerotic Cardiovascular Disease</u>		<u>2+ years</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr 6</u> , 19 <u>51</u> , to <u>Apr 13</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Apr 13</u> , 19 <u>51</u> , and that death occurred at <u>11:20 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>E. H. ESTES, Jr.</u> (Degree or title)		ADDRESS <u>U.S. NAVAL HOSPITAL April 14, 1951</u>	
DATE SIGNED <u>Apr 14, 1951</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Apr 17, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>W. W. Chambers, 517 11th Street, S.E., Washington, D.C.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

510916

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

1951

RECEIVED

MAY 17 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3916

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> TOWN <u>Chevy Chase</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>417 Turner St.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> TOWN <u>Chevy Chase</u> STREET ADDRESS (If rural, give location) <u>417 Turner St.</u>	
3. NAME OF DECEASED (Type or Print) <u>GERTRUDE</u> (First) <u>V. JOHNSON</u> (Middle) (Last)		4. DATE OF DEATH <u>April 22,</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>29 Aug. 1874</u>
9. AGE last birthday <u>76</u> yrs. <u>7</u> Months <u>23</u> Days <u>23</u> Hours <u>Min.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James B. Williams</u>		14. MOTHER'S MAIDEN NAME <u>Sarah R. Paxton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Carl L. Bush</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>3 Months?</u>
Immediate cause (a) <u>Cerebral Vascular Accident</u>			
Antecedent cause(s) (b) <u>Hypertension</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>83a</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 2/8, 1951, to 4/14, 1951, that I last saw the deceased alive on 4/14, 1951, and that death occurred at 7:00 m., from the causes and on the date stated above.

SIGNATURE William N. Gadol (Degree or title) ADDRESS 5016088 Georgetown Rd Md DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE <u>4-25-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Elbrook Church Cem.</u>	LOCATION (City, town, or county) <u>Washington, D. C.</u>	(State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>4-23-51</u>		REGISTRAR'S SIGNATURE <u>Helen S. Eberfeldt</u>		24. FUNERAL DIRECTOR <u>Robert D. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 24 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

3917

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>101 W. Leland St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Marshall</u>	(Middle) <u>H.</u>	(Last) <u>Jones</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Nov. 13, 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>State Hill, Penna.</u>
13. FATHER'S NAME <u>Frank Jones</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Marshall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>NONE</u>	17. INFORMANT AND ADDRESS <u>Same as #2</u>

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Chronic Pyelonephritis</u>		
600.0 Antecedent cause(s)	(b) <u>Pyelonephritis</u>		
133a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Hypertension & arteriosclerosis</u>		
II. OTHER SIGNIFICANT CONDITIONS		19. AUTOPSY?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
21. SUICIDE	INJURY		
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan. 6, 1957, to Apr. 6, 1957, that I last saw the deceased alive on Apr. 5, 1957, and that death occurred at 1:15 m., from the causes and on the date stated above.

SIGNATURE Robert A. Humphrey, M.D. ADDRESS 1009 Seminary Rd. Silver Spring, Md. DATE SIGNED April 9, 1957

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)
<u>Burial</u>	<u>Apr. 8, 1957</u>	<u>Seatonville</u>	<u>Ch. Penn. Seatonville, Penna.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>April 9, 1957</u>	<u>Francis Potter</u>	<u>Robert A. Humphrey</u>	<u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 11 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Bethesda, Rural</u> LENGTH OF STAY (in this place) <u>1 week</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda,</u> TOWN <u>Bethesda,</u> STREET ADDRESS (If rural, give location) <u>4504 Jones Bridge Road</u>				
3. NAME OF DECEASED (First) <u>Raymond</u> (Middle) <u>Crawford</u> (Last) <u>KARGE</u>	4. DATE (Month) (Day) (Year) OF DEATH <u>April 22,</u> 19 <u>51</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 29, 1895</u>	9. AGE last birthday <u>55</u> yrs. <u>07</u> Months <u>23</u> Days	If under 1 year <u>07</u> Months <u>23</u> Days	If under 24 hrs. <u>07</u> Hours <u>23</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not known</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME <u>George KARGE</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth McGINNIS</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>- - - - -</u>		17. INFORMANT AND ADDRESS <u>Wife: Laura R. KARGE</u>		
18. MEDICAL CERTIFICATION Same as item # 2						
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Myocardial Infarctions - Multiple</u>						<u>3 yrs</u>
Antecedent cause(s) (b) <u>Coronary Occlusions - Multiple</u>						<u>3 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Atherosclerotic HT. Disease</u>						<u>20 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Hepatic & Pulmonary Congestion</u>						
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)		
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Apr 16,</u> 19 <u>51,</u> to <u>Apr 22,</u> 19 <u>51,</u> that I last saw the deceased alive on <u>Apr 22,</u> 19 <u>51,</u> and that death occurred at <u>1:10 P.m.,</u> from the causes and on the date stated above.						
SIGNATURE <u>S. M. FOX, III</u>		(Degree or title) <u>LTJG, MC, USN</u>		ADDRESS <u>U.S. NAVAL HOSPITAL</u>		DATE SIGNED <u>April 23, 1951</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Apr 25, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REG. <u>APR 23, 1951</u>		REGISTRAR'S SIGNATURE <u>Eric Whittington</u>		24. FUNERAL DIRECTOR ADDRESS <u>R. A. Pumphrey, 7557 Wisconsin Avenue, Bethesda, Maryland.</u>		

MARGIN RESERVED FOR BINDING

UNITED STATES DEPARTMENT OF HEALTH
OFFICE OF VITAL STATISTICS
BUREAU OF DEATH

RECEIVED

APR 24 1951

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 279

1. PLACE OF DEATH. COUNTY <u>MONTG.</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>WASH.</u> COUNTY <u>D.C.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spg.</u>		LENGTH OF STAY (in this place) <u>16 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. #2</u>				STREET ADDRESS (If rural, give location) <u>15 E St. N.W.</u>	
3. NAME OF DECEASED (Type or Print) <u>Maryannet</u>		(First) <u>N.M.I.</u>		(Last) <u>Keogh</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>2/14/1869</u>	9. AGE last birthday <u>82</u> yrs.	4. DATE (Month) (Day) (Year) OF DEATH <u>April 12</u> 195 <u>1</u> If under 1 year If under 24 hrs Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work demanding most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. School</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
13. FATHER'S NAME <u>John M. Keogh</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u></u>		14. MOTHER'S MAIDEN NAME <u>Alice</u>	
		17. INFORMANT AND ADDRESS <u>D. HURKIN, 3059 S. Archambault St.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(2)

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF
INJURY m.

INJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 6, 1950 to Apr. 12, 1951, that I last saw the deceased

alive on ~~the~~
SIGNATURE

(Degree or title)

.....P.m., from the causes and on the date stated above.
ADDRESS DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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RECEIVED

APR 16 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

3320

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chevy Chase</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6969 Brookville Road</u>		STREET ADDRESS (If rural, give location) <u>6969 Brookville Road</u>	
3. NAME OF DECEASED (Type or Print) <u>MRS. ANNUNCIATA DARTON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 20, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 31, 1905</u>
9. AGE last birthday <u>45</u> yrs. <u>8</u> Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min.		10. BIRTHPLACE (State or foreign country) <u>Laramie, Wyoming</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nelson H. Darton</u>		14. MOTHER'S MAIDEN NAME <u>Alice W. Wasserbach</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Chevy Chase, Md</u> <u>William J. Kerlin, 6969 Brookville Rd.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) General Vascular Failure
(b) Cirrhosis of the Liver
(c)

INTERVAL BETWEEN ONSET AND DEATH

7 days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Carcinoma of the Breast

8 months

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Aug 1, 1950, to April 20, 1951, that I last saw the deceased

alive on April 20, 1951, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

SIGNATURE Francis J. Sharpe (Degree or title) ADDRESS 3323 - O - St. N.W. Washington D.C. 4/20/51 DATE SIGNED 4/20/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/23/51</u>		NAME OF CEMETERY OR CREMATORY <u>MT OLIVET CEM.</u>		LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
DATE REC'D BY LOCAL REG. <u>Apr 23/51</u>		REGISTRAR'S SIGNATURE <u>Francis J. Sharpe</u>		24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons</u>		ADDRESS <u>1756 Pa. Ave Washington, D. C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 25 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3921 223-

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>South Maryland</u> COUNTY <u>PRINCE GEORGES</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Take Pl.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>South English</u>	
TOWN <u>Washington San + Hospital</u>		TOWN <u>Northville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San + Hospital</u>		STREET ADDRESS (If rural, give location) <u>4003 Quintana St.</u>	
3. NAME OF DECEASED (Type or Print) <u>LENORA</u>	(First) <u>BLANCHE</u>	(Middle) <u>KLEIN</u>	(Last)
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>9-17-76</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE last birthday <u>74</u> yrs.
13. FATHER'S NAME <u>Emmanuel Stoner</u>		14. MOTHER'S MAIDEN NAME <u>Maxia Royer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
(If year, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mrs. Vera Woods (same) daughter</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cerebral hemorrhage</u>	<u>hours</u>	
260X Antecedent cause(s) (b) <u>diabetes mellitus, coronary insufficiency</u>	<u>2 years</u>	
61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>obesity, arteriosclerosis generalis</u>	<u>years</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/18, 1949, to 4/19, 1957, that I last saw the deceased alive on 4/18, 1957, and that death occurred at 7:20 p.m., from the causes and on the date stated above.

SIGNATURE Frederic Bernum M.D. ADDRESS Verkams Park DATE SIGNED 4/19/57

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Removal</u>	<u>April 24, 1957</u>	<u>Frederick Md.</u>	<u>Frederick Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>4-10-57</u>	<u>John Dodd</u>	<u>Cherry Chase</u>	<u>5101 Wisc. N.W.</u>
		<u>Greenwood Home Park D.C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH COUNTY <u>Montgomery Co. Takoma Park</u> <u>11 Philadelphia Ave</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>not known + unable to learn</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Takoma Park Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Nursing Home of Mrs. Corran</u> <u>11 Philadelphia St.</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Lulu</u>	(First) <u>Maie</u>	(Last) <u>KLINE</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>19</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Unable to learn this</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursemaid. Selling Pickled Eggs from house to house</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>approx 70 yrs.</u> If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Eminence Ky.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jones</u> (Son did not know this)		14. MOTHER'S MAIDEN NAME <u>Unknown by her son</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>?</u>	
17. INFORMANT <u>Hanson McKline 625 Market St. San Francisco Calif</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>Right side pneumonia, probably from aspiration of mucus</u>	(a) <u>Lower lobe left also involved</u>	<u>Apr 17 to Apr 19, 1951</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Paralytic stroke by in 1946 Fractured rt thigh in Dec '47</u> <u>In over a year she has had to be fed with care and by diet + totally unable to speak</u> (c) <u>Paralysis of vocal + swallowing muscles in Feb 1950 becoming worse in 2 or 3 weeks</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>see (c) above + (b)</u>		
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Sept. 16, 1948, to Apr 19, 1951, that I last saw the deceased alive on Apr 19, 1951, and that death occurred at 12:27 p.m., from the causes and on the date stated above.

SIGNATURE <u>G. P. Barger md</u>	(Degree or title)	ADDRESS <u>1125 Buchanan St., N. W.</u>	DATE SIGNED <u>Apr 19, 1951</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>	DATE THEREOF <u>Apr 19, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	LOCATION (City, town, & county) (State) <u>Eastland Md.</u>
DATE REC'D BY LOCAL REG <u>4-19-51</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Deal Funeral Home</u>	ADDRESS <u>4812 Georgia Ave Wash DC</u>

RECEIVED
APR 23 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

3923

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Virginia COUNTY Alexandria	
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) Alexandria	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural, give location) 522 Bertland Street	
3. NAME OF DECEASED (Type or Print) June (none) Ann (none)		4. DATE OF DEATH (Month) (Day) (Year) April 17, 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Apr 14, 1951
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	9. AGE last birthday 00 yrs. 00 Months 04 Days
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME James D. KNIGHT		14. MOTHER'S MAIDEN NAME Sarah T. JODOIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service) - - - - -		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT AND ADDRESS Mother: Sarah T. KNIGHT		18. MEDICAL CERTIFICATION Same as item # 2	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Congenital Heart Immaturity			
Antecedent cause(s) (b) Prematurity			
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Apr 14, 1951 , to Apr 17, 1951 , that I last saw the deceased alive on Apr 17, 1951 , and that death occurred at 3:31 P.m. , from the causes and on the date stated above.			
SIGNATURE E. W. SEDERSTROM		ADDRESS U.S. NAVAL HOSPITAL	
DATE SIGNED April 19, 1951			
23. BURIAL CREMATION REMOVAL (Specify) Disposition		DATE THEREOF Apr 19, 1951	
LOCATION Bethesda, Maryland		REGISTRAR'S SIGNATURE Edith Whittington	
24. FUNERAL DIRECTOR None		ADDRESS	

20414/181321

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

APR 20 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>5605 Roosevelt St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>James</u> (Middle) <u>Ra</u> (Last) <u>Go</u>	4. DATE OF DEATH	(Month) <u>4</u> (Day) <u>12</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 14, 1863</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Printed</u>	9. AGE last birthday <u>87</u> yrs.	If under 1 year Months <u>5</u> Days <u>15</u> Hours <u>15</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Milton N.J.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Ra Go</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>1909</u>	
17. INFORMANT AND ADDRESS <u>Hubert Ra Go Jr.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

186a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Myocardial failure with pulmonary edema due to myocardial degeneration & right bundle branch block.

(b) Benign Prostatism with partial bladder obstruction.

(c) Arteriosclerosis, generalised.

INTERVAL BETWEEN ONSET AND DEATH

3 days

5 yrs.

1 yr.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>2.9.51</u>	19b. MAJOR FINDINGS OF OPERATION <u>Enter trochanteric fracture rt. hip</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>Fracture rt. Hip</u>	PLACE (Home, farm, factory, street, office hldg., etc.) <u>Home</u>	(CITY OR TOWN) <u>Bethesda</u> (COUNTY) <u>Mont.</u> (STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2</u> <u>8</u> <u>51</u> <u>10a.m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Slipped on ice & fell</u>

22. I hereby certify that I attended the deceased from Nov., 1950, to April 12 1951, that I last saw the deceased

alive on 4.11., 1951, and that death occurred at 4:32 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>	DATE THEREOF <u>14 Apr 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	LOCATION (City, town, or county) <u>Suitland Md.</u>
DATE REC'D BY LOCAL REG. <u>4-18-51</u>	REGISTRAR'S SIGNATURE <u>Helen J. Ebenfelder</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	ADDRESS <u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3924

RECEIVED

APR 17 1951

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

3925

214

Reg. Dist. No.....

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>D.C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
TOWN <u>Brooke Grove Farm</u>		TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Convalescent Home</u>		STREET ADDRESS <u>Kenasaw Apt.</u>	
3. NAME OF DECEASED (First) <u>Julia</u>	(Middle) <u>H</u>	(Last) <u>Waskey</u>	4. DATE OF DEATH (Month) <u>Apr.</u> (Day) <u>22</u> (Year) <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Oct. 10, 1860</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher & Librarian</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>91</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>Richard Waskey</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16. SOCIAL SECURITY No.		14. MOTHER'S MAIDEN NAME <u>Julia Fay Hunt</u>	
17. INFORMANT <u>Mr. Richard H. Underwood</u>		<u>nephew</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>year</u>
Immediate cause (a) <u>Uremia</u>				
443X Antecedent cause(s) (b) <u>Hypertensive Cardiovascular Disease</u>				
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 9/9, 1950, to 4/22, 1951, that I last saw the deceased alive on 4/20, 1951, and that death occurred at 11:10 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) DATE NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

REC April 23/51 Frances Potter The S.H. Hines Co. 2901-14 St. N.W.

093 VVV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 23 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

3926

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH-COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED-STATE <i>Maryland</i> COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Suburban Hospital</i>		STREET ADDRESS (If rural, give location) <i>9503 Millstead Drive</i>	
3. NAME OF DECEASED (Type or Print) <i>Theresa Claire Leahy</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>April 10 1951</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Single</i>	8. DATE OF BIRTH <i>10-25-07</i>
9. AGE last birthday <i>43</i> yrs.		10. BIRTHPLACE (State or foreign country) <i>Plainfield, N. J.</i>	
11. BIRTHPLACE (State or foreign country) <i>Plainfield, N. J.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>John J. Leahy</i>		14. MOTHER'S MAIDEN NAME <i>Mary Dooney</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT AND ADDRESS <i>Mac Leahy - 375 76th St, Brooklyn, NY</i>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

416X
95b

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) *Cardiac Decompensation*

(b) *Rheumatic Heart Disease*

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 yrs?

20 years?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <i>SUICIDE</i>		PLACE (Home, farm, factory, street, OF office hldg., etc.) <i>INJURY</i>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *April 10, 1951*, to *Same*, 19....., that I last saw the deceased alive on *April 10, 1951*, and that death occurred at *9:05* p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial - Roman</i>		DATE THEREOF <i>4/11/51</i>		NAME OF CEMETERY OR CREMATORY <i>St. John's</i>		LOCATION (City, town, or county) (State) <i>Schenectady, New York</i>	
DATE REC'D BY LOCAL REG. <i>4/11/51</i>		REGISTRAR'S SIGNATURE <i>Frances Potter</i>		24. FUNERAL DIRECTOR <i>Robert A. Humphrey - Beth. Md.</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 12 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

3927

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San & Hosp. P.</u>		STREET ADDRESS (If rural, give location) <u>8318 - 16 St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Lorick</u> (Middle) <u>Pierce</u> (Last) <u>Hiles</u>	4. DATE OF DEATH (Month) <u>4</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10-14-76</u>
9. AGE last birthday <u>74 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Broker</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country) <u>Greensboro Ala.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Jesse V. Hiles</u>	
14. MOTHER'S MAIDEN NAME <u>Florence T. Griggin</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>	
16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT AND ADDRESS <u>Hospital Records.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Uremia</u>		<u>1 wk</u>
Antecedent cause(s) (b) <u>Carcinoma of Penis</u>		<u>2 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Carcinoma of Bladder</u>		<u>4 yrs</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>May 6</u> , 19 <u>47</u> , to <u>April 10</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>April 10</u> , 19 <u>51</u> , and that death occurred at <u>11:15</u> p.m., from the causes and on the date stated above.		
SIGNATURE <u>Francis J. Weller</u>	(Degree or title)	ADDRESS <u>1835 EYE ST NW D.C.</u>
DATE SIGNED <u>April 11, 51</u>		
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>4-12-1951</u>	NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEM.</u>
LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>		
DATE REC'D BY LOCAL REG. <u>4/12/51</u>	REGISTRAR'S SIGNATURE <u>Francis J. Weller</u>	24. FUNERAL DIRECTOR <u>Joseph Samuels</u>
ADDRESS <u>1707 1/2 D.C.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 151

RECEIVED

APR 16 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3928 218

1. PLACE OF DEATH- <u>BROOKVILLE</u> COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL - UNITY</u> LENGTH OF STAY (in this place) <u>4 YRS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL - near Unity</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>---</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>JEFF</u> (Middle) <u>-</u> (Last) <u>LIVESAY</u>		4. DATE OF DEATH (Month) <u>APRIL</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 4, 1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>day laborer</u>	9. AGE last birthday <u>83</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>HANCOCK COUNTY - TENN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JEFF LIVESAY</u>		14. MOTHER'S MAIDEN NAME <u>CHARLOTTE LAMB</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT AND ADDRESS <u>BONNIE JAMES</u> <u>BROOKVILLE MD. Rt 21</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>ACUTE CONGESTIVE HEART FAILURE</u>		<u>2 DAYS</u>
Antecedent cause(s)	(b) <u>HYPERTENSIVE CARDIO-VASCULAR-RENAL DISEASE</u>		<u>5 YRS.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>CHRONIC CONGESTIVE HEART FAILURE</u>		<u>1 YR.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from DEC., 1950, to APRIL 10, 1951, that I last saw the deceased alive on APRIL 10, 1951, and that death occurred at 125 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Ralph L. Nicholson, M.D. ADDRESS Danvers, Maryland DATE SIGNED 4/10/51

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE <u>April 13, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Baptist Lisbon</u>	LOCATION (City, town, or county) <u>Howard Co MD</u>	(State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>4/13/51</u>	REGISTRAR'S SIGNATURE <u>Quinn D. Bell</u>	24. FUNERAL DIRECTOR <u>Roy W. Barber</u>	ADDRESS <u>Lortonville</u>	

828/05 M9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. AN

RECEIVED
APR 23 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>rural - Dayton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County General Hospital, Inc.</u>		STREET ADDRESS (If rural, give location) <u>Vineyard Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Cora</u> (Middle) <u>J.</u> (Last) <u>Long</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>22</u> (Year) <u>1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>April 10, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	9. AGE last birthday <u>77</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>August Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Matilda ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Bertha Carter (daughter) Dayton, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

cachexia

INTERVAL BETWEEN ONSET AND DEATH

1 month

Antecedent cause(s)

(b)

adenocarcinoma of the left breast with metastases18 months

11. OTHER SIGNIFICANT CONDITIONS

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

Conditions contributing to the death but not related to the disease or condition causing death.

April 15, 1950adenocarcinoma of the left breast

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 23, 1946, to April 22, 1951, that I last saw the deceasedalive on April 21, 1951, and that death occurred at 10:00 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Charles S. Whitaker, M.D. Clarksville, Md.April 22, 1951

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4-22-51Bertha B. LawlerF.C. Higginbotham, Elliott City, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 27 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

3930

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH - COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED - COUNTY STATE <u>Washington D.C.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural, give location) <u>4622 Ellicott St. N.W.</u>			
3. NAME OF DECEASED (Type or Print) <u>William</u>		(First)		(Middle) <u>Lee</u>		(Last) <u>Loudermilk</u>	
5. SEX <u>m</u>		6. COLOR OR RACE <u>w</u>		7. SINGLE, <u>MARRIED</u> , WIDOWED, DIVORCED, (Specify)		4. DATE OF DEATH (Month) (Day) (Year) <u>April 9 1951</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stonecutter</u>		10b. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>June 26, 1879</u>		9. AGE last birthday <u>71</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Columbus Loudermilk</u>				14. MOTHER'S MAIDEN NAME <u>Mary Casteel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT AND ADDRESS <u>Claudia Warner - 4323 River Rd. N.W.</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Pulmonary edema</u>						<u>2 days</u>	
Antecedent cause(s) (b) <u>Chronic hypertension heart disease</u>						<u>5 yrs.</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Generalized arteriosclerosis</u>						<u>10 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>			
HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>Apr 8</u> , 19 <u>51</u> , to <u>Apr 9</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Apr 9</u> , 19 <u>51</u> , and that death occurred at <u>7:26 P.m.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Emil S. Bauerfeld M.D.</u>				(Degree or title)		DATE SIGNED <u>4/10/51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>Apr 11 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>		LOCATION (City, town, or county) (State) <u>Bladensburg Md</u>	
DATE REC'D BY LOCAL REG. <u>4/11/51</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		24. FUNERAL DIRECTOR <u>Cheryl Chase - 5101 Wisc. N.W.</u>		ADDRESS <u>Funeral Home 584 VVV</u>	

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED

APR 12 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

3931

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write nearest town) <u>Bethesda</u> OR <u>give nearest town</u> <u>5 da.</u>		CITY (If outside corporate limits, write nearest town) <u>Bethesda</u> OR <u>give nearest town</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>		STREET ADDRESS (If rural, give location) <u>8801 Ridge Road</u>	
3. NAME OF DECEASED (First) <u>Margaret</u> (Middle) <u>Ida</u> (Last) <u>Lovejoy</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>7</u> (Year) <u>1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 3, 1880</u>
9. AGE last birthday <u>71</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Alabama</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	13. FATHER'S NAME <u>James M. Young</u>	14. MOTHER'S MAIDEN NAME <u>Mary Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS <u>son.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cardiac Decompensation

Antecedent cause(s)

(b) Carcinoma of stomach(c) stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

one week1 year?II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from July 1, 1951, to April 6, 1951, that I last saw the deceased alive on April 6, 1951, and that death occurred at 11:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>	DATE THEREOF <u>4/10/51</u>	NAME OF CEMETERY OR CREMATORY <u>Eden Hill Co.</u>	LOCATION (City, town, or county) <u>Suella d Md</u> (State)
DATE REC'D BY LOCAL REG. <u>4/17/51</u>	REGISTRAR'S SIGNATURE <u>Helen Kurock</u>	24. FUNERAL DIRECTOR <u>Simmons Bros. 2007-Nichols</u> ADDRESS <u>as 85</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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APR 12 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Brookville Md</u>	
TOWN <u>Olney</u>		TOWN <u>Rural Brookville Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery Geo. I. Dr.</u>		STREET ADDRESS (If rural, give location) <u>-</u>	
3. NAME OF DECEASED (Type or Print) <u>Sammy</u> (First) <u>L.</u> (Middle) <u>Suther</u> (Last)		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>22</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Oct 26-1949</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>	9. AGE last birthday <u>1</u> yrs. <u>5</u> Months <u>27</u> Days <u>27</u> Hours <u>1</u> Min.
13. FATHER'S NAME <u>Samuel E. Suther</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		14. MOTHER'S MAIDEN NAME <u>Rodora E. Suther</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT AND ADDRESS <u>Mr. S. E. Suther</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

General Septicemia

INTERVAL BETWEEN ONSET AND DEATH

2 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Infect. Sept. Middlefinger

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.19a. DATE OF OPERATION none 19b. MAJOR FINDINGS OF OPERATION none

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT (Specify) ✓
SUICIDE
HOMICIDEPLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY ✓

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY ✓
m.INJURY OCCURRED While at Work ☐ Not While At work ☒HOW DID INJURY OCCUR? ✓22. I hereby certify that I attended the deceased from 4/22/51, 1951, to 4/22, 1951, that I last saw the deceasedalive on 4/22/51, 1951, and that death occurred at 10:10 P.M., from the causes and on the date stated above.SIGNATURE JMB

(Degree or title)

ADDRESS Montgomery Co MdDATE SIGNED 4/22/5123. BURIAL, CREMATION REMOVAL (Specify) BurialDATE THEREOF April 25, 1951NAME OF CEMETERY OR CREMATORY St. CarmelLOCATION (City, town, or county) Montgomery Co Md

(State)

DATE REC'D BY LOCAL REG. 4-24-51REGISTRAR'S SIGNATURE Gertrude B Fowler24. FUNERAL DIRECTOR Roy W. BordenADDRESS Stonemiller

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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APR 27 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

3934

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural- Cabin John</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural- Cabin John</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D #3 Bethesda, Md. Box 164</u>		STREET ADDRESS <u>RFD #3 Bethesda, Md. Box 164</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Bernard</u>	<u>I.</u>	<u>Marsden</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>30 Oct 1895</u>
9. AGE last birthday <u>55</u> yrs.		10. DATE OF DEATH <u>Apr 5 1957</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Franklin I. Marsden</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude L. Hill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Claire M. Kitchen</u>		Same as item # 1	

18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary occlusion</u> Antecedent cause(s) (b) <u>420.1 94a</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			<u>Found dead in bed.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Frank J. Broochast M.D.</u>		DATE SIGNED <u>8-5-57</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/8/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Potomac Church Cem.</u>		LOCATION (City, town, or county) (State) <u>Potomac, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>4-5-51</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	
REGISTRAR'S SIGNATURE <u>Allen K. Kowalski</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

583916



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
TOWN <u>Washington</u>		TOWN <u>Forest Glen</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington</u>		STREET ADDRESS <u>403 Forest Glen Rd</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>David</u> (Middle) <u>Houston</u> (Last) <u>Mathew</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>30</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2-21-80</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - Woodward & Lothrop</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>71</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel Mathew</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Charlton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If year, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Mabel Mathew 403 Forest Glen Rd</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Metastatic Carcinoma Breast Stem</u>			
Antecedent cause(s) (b) <u>445 Lumber Vehicle Carcinoma Parotid Gland</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>Fall 1949</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma (Mucocylindroid) Parotid Gland</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
HOMICIDE		INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19 <u>49</u> , to <u>April 30</u> 19 <u>57</u> , that I last saw the deceased alive on <u>April 22</u> , 19 <u>57</u> , and that death occurred at <u>6:50</u> am., from the causes and on the date stated above.			
SIGNATURE <u>Thomas Bradley</u> (Degree or title)		ADDRESS <u>2024 - R St N.E. Wash DC</u> DATE SIGNED <u>April 30 1957</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>5-2-57</u> NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u> LOCATION (City, town, precinct) (State) <u>Washington D.C.</u>	
DATE REC'D BY LOCAL REG. <u>4/30/57</u>		REGISTRAR'S SIGNATURE <u>J. Thomas D. [Signature]</u> 24. FUNERAL DIRECTOR <u>Wm. S. [Signature]</u> ADDRESS <u>2024 - R St N.E. Wash DC</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

MAY 5 1972

BUREAU V. J.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

3933

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write nearest town) <u>Frederick Fairhartsburg</u>		CITY (If outside corporate limits, write nearest town) <u>Frederick Fairhartsburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>EUGENIA</u> (Middle) <u>MC</u> (Last) <u>MAHON</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>20</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>JUNE 19, 1869</u>
9. AGE last birthday <u>81</u> yrs.		10. If under 1 year Months <u>0</u> Days <u>0</u> If under 24 hrs. Hours <u>0</u> Mins. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic own</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sylvester Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Bearers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>21</u>	
17. INFORMANT AND ADDRESS <u>John MC Mahon Fairhartsburg</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral hemorrhage (hemiplegia)

INTERVAL BETWEEN ONSET AND DEATH

6 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) hypertension

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify)

SUICIDE
HOMICIDE
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-18-1957, to 4-20-1957, that I last saw the deceased

alive on 4-20-1957, and that death occurred at 5:30 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

J. Brochart M.D. Fairhartsburg Md 4-23-57

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

April 24/57 Forest Oak Fairhartsburg Md Montgomery
April 23/57 Wanda L. Cooke Roy W. Barber Lyonsville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 25 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

3936

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>District of Columbia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>1607 22nd Street, S.E.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Leo</u>	(Middle) <u>(none)</u>	(Last) <u>MEAD</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>22</u> (Year) <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Officer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>US Navy</u>	8. DATE OF BIRTH <u>Jan 17, 1879</u>	9. AGE last birthday <u>72</u> yrs. <u>03</u> Months <u>03</u> Days
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>	13. FATHER'S NAME <u>Elder MEAD</u>	
14. MOTHER'S MAIDEN NAME <u>Rose HOWARD</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>SpAm. WW I & II</u>	
16. SOCIAL SECURITY No.		17. INFORMANT <u>Wife: Mamie MEAD</u>	

18. MEDICAL CERTIFICATION Same as item # 2

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Massive subdural & subarachnoid hemorrhage, left cerebral.

Antecedent cause(s)

(b) 186a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH
6 1/2 hrsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY <u>hospital</u>	(CITY OR TOWN) <u>Bethesda</u>	(COUNTY) <u>Monty</u>	(STATE) <u>md</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Apr. 22, 1951</u> <u>8 A. m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Fell, striking head on floor</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Frank J. BROCHART, M.D.

Gaithersburg, Maryland

April 23, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Apr 25, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	LOCATION (City, town, or county) <u>Arlington, Virginia</u>	(State)
--	-------------------------------------	--	--	---------

DATE REC'D BY LOCAL REG. <u>Apr 23, 1951</u>	REGISTRAR'S SIGNATURE <u>Edith Whittington</u>	24. FUNERAL DIRECTOR <u>W. W. Chambers, 517 11th Street, SE, Washington, D.C.</u>	ADDRESS <u>RDR</u>
---	---	--	-----------------------

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 24 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

3937

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4512 Chestnut St, Beth.Md.</u>		STREET ADDRESS <u>4512 Chestnut Street</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Maisha C. Moler</u>		4. DATE OF DEATH (Month) <u>Apr</u> (Day) <u>27</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>25 Dec. 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	9. AGE last birthday <u>53</u> yrs. <u>4</u> months <u>2</u> days
11. BIRTHPLACE (State or foreign country) <u>Millville, W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Eugene W. Moler</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Engle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY No. <u>579-221213</u>	
17. INFORMANT AND ADDRESS <u>W.Va.</u>		17. INFORMANT AND ADDRESS <u>Mrs. Betty Spiker-Kearneysville.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary occlusion

Antecedent cause(s)

(b) 4/20.1
94a
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

Sudden death

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial
1 May 1951Arlington NationalArlington, Virginia4/30/51Bessie M. ThompsonRobert A. Pumphrey-Bethesda, Md.Robert A. Pumphrey 682536

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED

MAY 2 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

3938

Reg. Dist. No. 211

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easthunting (rural)</u> LENGTH OF STAY (In this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easthunting (rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>near woodfield</u>		STREET ADDRESS (If rural, give location) <u>near woodfield</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Clifton</u> (Middle) <u>Breat</u> (Last) <u>Monroe</u>		4. DATE OF DEATH (Month) <u>ap</u> (Day) <u>2</u> (Year) <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Oct 7 - 1950</u>
9. AGE last birthday <u>5</u> yrs. <u>5</u> months <u>35</u> days		10. IF under 1 year If under 24 hrs Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Blount, md</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Clifton Leroy Lyler</u>	
14. MOTHER'S MAIDEN NAME <u>Shirley Monroe</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Bessie E. Monroe</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
501X Immediate cause (a) <u>Tracheo-bronchitis</u>		<u>2 weeks</u>
106C Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c) <u>Found dead in bed</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE (Degree or title) <u>Frank J. Broschart, M.D.</u>	ADDRESS <u>Easthunting md</u>	DATE SIGNED <u>4-2-51</u>
23. BURIAL, CREMATION REMOVAL, (Specify) <u>BURIAL</u>	DATE THEREOF <u>apv. 4, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>BARTONSVILLE Col. Cemetery</u>
LOCATION (City, town, or county) (State) <u>BARTONSVILLE - MD</u>	24. FUNERAL DIRECTOR <u>M.R. Fitchison & Son, Frederick MD.</u>	ADDRESS
DATE REC'D BY LOCAL REG. <u>4/2/51</u>	REGISTRAR'S SIGNATURE <u>Lella W. Burdette</u>	

200070141406

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED

SECTION

RECEIVED
APR 5 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH- COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL and give nearest town) OLNEY		CITY (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG	
HOSPITAL OR INSTITUTION OR STREET ADDRESS THE MONTGOMERY COUNTY GENERAL HOSPITAL INC.		STREET ADDRESS R/F.D.	
3. NAME OF DECEASED (Type or Print) JAMES (First) MOUNT (Last)		4. DATE OF DEATH (Month) (Day) (Year) APRIL 8 1951	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 10/22/1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) APPRAISER		10b. KIND OF BUSINESS OR INDUSTRY ORPHANS' COURT	9. AGE last birthday 78 yrs.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN R. MOUNT		14. MOTHER'S MAIDEN NAME SUSAN MOLESWORTH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS HOSPITAL RECORDS	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) *Infra-cranial hemorrhage*
(b) *Left*
(c) *Arterio sclerosis*

INTERVAL BETWEEN ONSET AND DEATH

5 weeks

Unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *Mar. 9, 1951*, to *April 8, 1951*, that I last saw the deceased alive on *April 8, 1951* and that death occurred at *10 p.m.* from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 4-11-51		NAME OF CEMETERY OR CREMATORY Hamasaus Cem		LOCATION (City, town, or county) (State) Hamasaus, Ind	
DATE REC'D BY LOCAL REG. 4-10-51		REGISTRAR'S SIGNATURE Bertrude B Fowler		24. FUNERAL DIRECTOR Roy W Barber		ADDRESS Saytonville Maryland	

300936

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 16 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>821 Heron Drive</u>		STREET ADDRESS (If rural, give location) <u>7908 Woodbury Drive</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mary</u> (Middle) <u>E.</u> (Last) <u>Murphy</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>14</u> (Year) <u>19 51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 4, 1887</u>
9. AGE last birthday <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Lamasco, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter R. Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Mary M. McCormick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mr. Robert H. Murphy, Silver Spring, Maryland</u>		17. INFORMANT AND ADDRESS <u>7908 Woodbury Drive</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>ACUTE CONGESTIVE HEART FAILURE</u>		<u>2 days</u>
Antecedent cause(s) (b) <u>HODG-KIN'S DISEASE</u>		<u>3 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>II MITRAL INSUFFICIENCY</u>		<u>10 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from July, 1948, to April, 1951, that I last saw the deceased alive on April 12, 1951, and that death occurred at 4 A. m., from the causes and on the date stated above.

SIGNATURE L. B. Snow M.D. ADDRESS Silver Spring, Md. DATE SIGNED 4-14-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/16/51</u>		NAME OF CEMETERY OR CREMATORY <u>Colesville Cemetery</u>		LOCATION (City, town, or county) (State) <u>Colesville, Montgomery Co. Md.</u>	
DATE REC'D BY LOCAL REG. <u>Apr 16 1951</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		24. FUNERAL DIRECTOR <u>Warner & Pumphrey</u>		ADDRESS <u>8434 Ga. Ave., Silver Spring Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 18 1951

BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>District of Columbia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>2426 Iverson Street, S.E.</u>	
3. NAME OF DECEASED (First) <u>Charles</u> (Middle) <u>Robertson</u> (Last) <u>NOBLE</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>April 13, 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Apr 8, 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>00</u> yrs. <u>00</u> months <u>05</u> days
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Harry R. NOBLE</u>		14. MOTHER'S MAIDEN NAME <u>Louise McCRACKEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Father: Harry R. NOBLE</u>	

18. MEDICAL CERTIFICATION <u>Same as item # 2</u>		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Sepsis ?staph aureus.</u>		<u>5d</u>
Antecedent cause(s) (b) <u>generalized hemorrhagic dermatitis</u>		<u>rd</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>scleroderma</u> <u>153</u>		<u>rd</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 8, 1951, to Apr 13, 1951, that I last saw the deceased alive on Apr 13, 1951, and that death occurred at 1:25 A.m., from the causes and on the date stated above.

SIGNATURE S. J. Winter (Degree or title) ADDRESS U.S. NAVAL HOSPITAL DATE SIGNED April 14, 1951

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF Apr 17, 1951 NAME OF CEMETERY OR CREMATORY Arlington National LOCATION (City, town, or county) (State) Arlington, Virginia

DATE REC'D BY LOCAL REG. Apr 14, 1951 REGISTRAR'S SIGNATURE Edith Whittington 24. FUNERAL DIRECTOR ADDRESS R. A. Pumphrey, 7557 Wisconsin Avenue, Bethesda, Maryland.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3941

204081222394

RECEIVED
APR 17 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2-17

3942

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County General Hospital, Inc.,</u>		STREET ADDRESS (If rural, give location) <u>Rt. 3</u>	
3. NAME OF DECEASED (Type or Print) <u>Ettie</u> (First) (Middle) (Last) <u>Noland</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 19 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1895-66</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Halal McAbbe</u>		14. MOTHER'S MAIDEN NAME <u>Sophie Sedgwick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Hospital record</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Acute myocarditis3 days

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-16, 1951, to 4-19, 1951, that I last saw the deceasedalive on 4-19, 1951, and that death occurred at 6:55 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATOR

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4-23-51Gertrude B. LavelleRobert A. Snowdley720826 Locust Hill Rd

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

APR 27 1954

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

3943

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BETHESDA</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BETHESDA</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VISITATION CONVENT</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>SISTER M.</u>	(Middle) <u>ELIZABETH</u>	(Last) <u>PEDERZINI</u>
4. DATE OF DEATH	(Month) <u>APRIL</u>	(Day) <u>28</u>	(Year) <u>1951</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>12/8/62</u>
9. AGE last birthday <u>88</u> yrs.		10. If under 1 year Months	11. If under 24 hrs. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RELIGIOUS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CATHOLIC NUN</u>	11. BIRTHPLACE (State or foreign country) <u>ITALY</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ANGELO PEDERZINI</u>	
14. MOTHER'S MAIDEN NAME <u>OLISA TOMASONI</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT AND ADDRESS <u>CONVENT RECORDS</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)-----

Heart Failure

Antecedent cause(s)

(b)-----

Hypertensive Heart Disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)-----

INTERVAL BETWEEN ONSET AND DEATH

Chronic

10 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June, 1941, to April 28, 1951, that I last saw the deceased

alive on April 27, 1951, and that death occurred at 7:40 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>APRIL 30/51</u>	NAME OF CEMETERY OR CREMATORY <u>CONVENT CEMETERY</u>	LOCATION (City, town, or county) <u>BETHESDA</u>	(State) <u>MARYLAND</u>
DATE REC'D BY LOCAL REG. <u>4-29-51</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Francis Collins 3821 14th N.W. Wash. D.C.</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

078 896

RECEIVED
MAY 1 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

3944

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9319 Caroline Ave.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> TOWN STREET ADDRESS (If rural, give location) <u>9319 Caroline Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>DARLEEN</u>	(First) <u>LILLIAN</u>	(Middle) <u>Pisani</u>	(Last)
4. DATE OF DEATH (Month) <u>April</u> (Day) <u>1</u> (Year) <u>1951</u>	5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. SINGLE, MARRIED WIDOWED, DIVORCED, (Specify)		
8. DATE OF BIRTH <u>Aug. 19, 1907</u>	9. AGE last birthday <u>43</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Dodge, Nebraska</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Charles Gohr</u>	14. MOTHER'S MAIDEN NAME <u>Emma Yunek</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT AND ADDRESS <u>Silver Spring, Md.</u> <u>Mr. Ralph M. Pisani, 9319 Caroline Ave.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) carcinomatosis

Antecedent cause(s)

(b) malignant bronchial cell tumor of ovaries (Bilateral)

(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

3 yearsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>1948</u>	19b. MAJOR FINDINGS OF OPERATION <u>Bilateral malignant tumor of ovaries & metastasis</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1948, to April, 1951, that I last saw the deceased alive on April, 1951, and that death occurred at 3:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Edward B. Wilson Jr. Md. 1801-Ex 88-26410 April 51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 4, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	LOCATION (City, town, or county) <u>Prince Geo. County</u> (State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>April 3, 1951</u>	REGISTRAR'S SIGNATURE <u>Frances Potter</u>	24. FUNERAL DIRECTOR <u>Warner E. Humphrey</u>	ADDRESS <u>8434 Ga. Ave., Silver Spring Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-1



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

3945

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chevy Chase</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6800 Meadow Lane</u>		STREET ADDRESS (If rural, give location) <u>6800 Meadow Lane</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>CHRISTINE STEVENS POLK</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 3, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>7 Dec. 1870</u>
9. AGE last birthday <u>80</u> yrs.		10. If under 1 year: Months <u>4</u> Days <u>26</u> If under 24 hrs.: Hours <u> </u> Mins. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Newton, Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Henry C. Meyer</u>		14. MOTHER'S MAIDEN NAME <u>Alithia Stevens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Julia Hunsicker (same as item 1)</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Ventricular Fibrillation - Respiratory Arrest</u>			
Antecedent cause(s) (b) <u>Chronic Degenerative Heart Failure</u>			
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) <u>Senescent Heart Failure</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 1, 1950</u> , to <u>April 3, 1951</u> , that I last saw the deceased alive on <u>April 3, 1951</u> , and that death occurred at <u>6:35 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>William B. Ralph M.D. - 1834 Connecticut Ave. N.W. - D.C. 4/3/51</u>		DATE SIGNED <u>4/3/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>		DATE THEREOF <u>5 Apr 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>4-4-51</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	
REGISTERAR'S SIGNATURE <u>Helen Kurvae</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 275

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville, MD</u>	
TOWN <u>Suburban Hosp.</u>		TOWN <u>Rockville, MD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Mary Stuart Pugh</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 7 1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4/23-1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>66</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>David Pugh - Rockville, MD</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) PERNICIOUS VOMITING - ACIDOSIS5 DAYS

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) ARTERIOSCLEROTIC HEART DISEASE15 YRS.(c) LOBAR PNEUMONIA, Hypostatic.4 DAYS

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

(9-20-51 ams)

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from APRIL 4, 1951, to APRIL 7, 1951, that I last saw the deceasedalive on APRIL 6, 1951, and that death occurred at 1:50 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Gordon R. Rosenbly M.D. Rockville, Md 4/7/51

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>April 9/51</u>	<u>Monocacy</u>	<u>Rockville, Md</u>
DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>April 7/51</u>	<u>[Signature]</u>	<u>William B. Hilton</u>	<u>Barnsville, Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 20 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>PITTSBURGH</u> COUNTY <u>ALLEGHENY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u> LENGTH OF STAY (in this place) <u>2 MONTHS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>PENNSYLVANIA</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3008 BLUE RIDGE AVE.</u>		STREET ADDRESS (If rural give location) <u>211 - 2nd AVENUE</u>	
3. NAME OF DECEASED (Type or Print) <u>LILLIAN</u> (Middle) <u>RAWNSLEY</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>11</u> (Year) <u>1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>SEPT. 26, 1885</u>
9. AGE last birthday <u>65</u> yrs.		10. If under 1 year: Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>YORKSHIRE - ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>WALTER WADSWORTH</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET STACEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT <u>DAUGHTER.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>13 MONTHS</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Generalized carcinomatosis</u>		
Antecedent cause(s) (b) <u>CARCINOMA of LEFT BREAST - METASTASIS TO LUNGS, PELVIS</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>OPERATED ON - RADICAL MASTECTOMY (LEFT) - in MARCH 1950.</u>		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>NONE</u>		19a. DATE OF OPERATION <u>NONE</u>		19b. MAJOR FINDINGS OF OPERATION <u>NONE</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>HOMICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) <u>SILVER SPRING, MONTGOMERY, MD.</u>		(COUNTY) <u>MD.</u>	
TIME (Month) (Day) (Year) (Hour) <u>OF INJURY</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>ARR</u>			

22. I hereby certify that I attended the deceased from 4/11/51, 1951, to 4/11/51, 1951, that I last saw the deceased alive on 4/10/51, 1951, and that death occurred at 12:10 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Transport</u>		DATE THEREOF <u>4/12/51</u>		NAME OF CEMETERY OR CREMATORY <u>Jefferson Memorial Park</u>		LOCATION (City, town, or county) <u>Pittsburgh Pa.</u>		(State) <u>Pa.</u>	
DATE REC'D BY LOCAL REG. <u>April 12, 1951</u>		REGISTRAR'S SIGNATURE <u>Frances Tetter</u>		24. FUNERAL DIRECTOR <u>W W Chambers & Co</u>		ADDRESS <u>1400 Chapin St NW</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 16 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

3948

Reg. Dist. No. 218

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Faithsburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Faithsburg Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Essexbury Methodist Home</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Mattie</u> (First) <u>Spencer</u> (Middle) <u>Richard</u> (Last)		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>12</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb 9, 1907</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>n</u>	9. AGE last birthday <u>84</u> yrs. <u>3</u> Months <u>3</u> Days
11. BIRTHPLACE (State or foreign country) <u>Berkley Co - W. Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edw. Fred. Kinner</u>		14. MOTHER'S MAIDEN NAME <u>Martha Spencer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>Methodist Home Records</u>	
17. INFORMANT AND ADDRESS <u>Methodist Home Records</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Hemiplegia right side</u>		
Antecedent cause(s) (b) <u>352X</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>83d</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertension</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 5, 1951, to Apr 12, 1951, that I last saw the deceased alive on Apr 12, 1951, and that death occurred at 1230 P.m., from the causes and on the date stated above.

SIGNATURE Ministry, nys (Degree or title) ADDRESS Faithsburg Md. Apr 12, 1951 DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>5/12/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Dale</u>	LOCATION (City, town, or county) (State) <u>Montgomery Md.</u>
DATE REC'D BY LOCAL REG. <u>Apr 12, 1951</u>	REGISTRAR'S SIGNATURE <u>Alfred L. Cooke</u>	24. FUNERAL DIRECTOR <u>Howard E. Brown</u>	ADDRESS <u>Montgomery</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

APR 16 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD.</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>601 E. Leland Street</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>GEORGE MELBOURNE ROGERS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 12 1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>April 5, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>52</u> yrs.
11. FATHER'S NAME <u>Geo Rogers</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. MOTHER'S MAIDEN NAME <u>Leafie Culbertson</u>		14. INFORMANT AND ADDRESS <u>Fred C. Smith, MD 2301 Conn Ave NW, Wash., DC</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WWI</u>		16. SOCIAL SECURITY No.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH

8 hrs

Antecedent cause(s)

(b) Arterial Hypertension20 yrs(c) Cardiac enlargement10 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Hypertension over 20 years period.20 yrs

19a. DATE OF OPERATION

none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY April 12 1951 INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1973 to April 17 51, that I last saw the deceasedalive on April 17 1951, and that death occurred at 11 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

April 16/51Frances TottenJos. Lawler's Sons, Wash., D.C.055879

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 18 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

3950

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Kensington</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
TOWN <u>Kensington</u>		TOWN <u>Kensington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>42 West Washington St.</u>		STREET ADDRESS (If rural, give location) <u>42 West Washington St.</u>	
3. NAME OF DECEASED (First) <u>William</u> (Middle) <u>Howell</u> (Last) <u>Ronsaville</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct. 14, 1866</u>
9. AGE last birthday <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner, Natl. Surety Bonding Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>David W. Ronsaville</u>		14. MOTHER'S MAIDEN NAME <u>Isabel Howell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>123-12-7123 A</u>	
17. INFORMANT AND ADDRESS <u>Miss Virginia Ronsaville, Kensington</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Hypostatic Pneumonia</u>		<u>2 days</u>
Antecedent cause(s) (b) <u>Carcinoma of Parotid gland with metastasis</u>		<u>2 1/2 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>Dec. 1948</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Parotid gland</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>142.1</u>	INJURY OCCURRED While at <u>Work</u> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 14, 1951, to Apr. 16, 1951, that I last saw the deceased alive on Apr. 16, 1951, and that death occurred at 11:35 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Katharine A. Chapman, M.D. ADDRESS 30 West Baltimore St. Kensington, Md. DATE SIGNED Apr. 16, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>4/19/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
DATE REC'D BY LOCAL REG. <u>April 18/51</u>	REGISTRAR'S SIGNATURE <u>Frances Potter</u>	24. FUNERAL DIRECTOR <u>Warner & Humphrey</u>	ADDRESS <u>8434 Ga. Ave., Silver Spring Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

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290726

RECEIVED
APR 20 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

3951

1. PLACE OF DEATH- COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE _____ COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-ROCKVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Waverly Sanatorium</u>		STREET ADDRESS _____	
3. NAME OF DECEASED (Type or Print) <u>ANNA</u> (First)	<u>BELLE</u> (Middle)	<u>ROUNTREE</u> (Last)	4. DATE OF DEATH <u>April</u> (Month) <u>10</u> (Day) <u>1961</u> (Year)
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 4-1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	9. AGE last birthday <u>86</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Harrison H. Darby</u>		14. MOTHER'S MAIDEN NAME <u>Nancy E. Huntley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. _____	
17. INFORMANT <u>C. A. Miller</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Chronic Nephritis - & Uremia</u>	<u>1 yr.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Chronic Cystitis & attacks of Pyelonephritis</u>	<u>2 yrs.</u>
	(c) <u>Generalized Arteriosclerosis with Hypertension</u>	<u>10 yrs.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Amphylorosis of Rt hip & leg causing confinement to bed</u>		<u>14 yrs.</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) _____	PLACE (Home, farm, factory, street, OF office bldg., etc.) _____	(CITY OR TOWN) _____ (COUNTY) _____ (STATE) _____
TIME (Month) (Day) (Year) (Hour) OF INJURY _____	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 31 March, 1951., to 10 April, 1961., that I last saw the deceased alive on 7 April, 1961., and that death occurred at 4:00 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>4-15-1951</u>	NAME OF CEMETERY OR CREMATORY <u>MORGANTOWN, PA.</u>	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. <u>Apr 12, 1951</u>	REGISTRAR'S SIGNATURE <u>Frances Potter</u>	24. FUNERAL DIRECTOR <u>W. J. Hawley & Sons</u>	ADDRESS <u>1756 Palmyra Wash, DC</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 16 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Virginia</u> COUNTY <u>Arlington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>813 South Quincey Street</u>	
3. NAME OF DECEASED (First) <u>James</u> (Middle) <u>Allen</u> (Last) <u>RUSSELL</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>25</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 25, 1900</u>
9. AGE last birthday <u>50</u> yrs. <u>09</u> mos. <u>00</u> days		10. If under 1 year <u>09</u> mos. <u>00</u> days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Various</u>	
11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William A. RUSSELL</u>		14. MOTHER'S MAIDEN NAME <u>Florence DAVIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY No. <u>- - - - -</u>	
17. INFORMANT AND ADDRESS <u>Wife: Celia R. RUSSELL</u>		18. MEDICAL CERTIFICATION <u>Same as item # 2</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Rupture, Aorta</u>		<u>16 hours</u>	
Antecedent cause(s) (b) <u>Atherosclerosis Aorta</u>		<u>10 years</u>	
(c) <u>Hypertensive Cardiovascular Disease</u>		<u>20 years</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr 25, 1951</u> , to <u>Apr 25, 1951</u> , that I last saw the deceased alive on <u>Apr 25, 1951</u> , and that death occurred at <u>7:20 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>J. W. FLYNN, LTJG, MC, USN</u>		ADDRESS <u>U.S. NAVAL HOSPITAL</u>	
DATE SIGNED <u>April 26, 1951</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Apr 30, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>W. W. Chambers, 3072 M Street, NW, Washington, D.C.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

3952

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

OFFICE OF THE REGISTRAR

CERTIFICATE OF DEATH

NAME	
AGE	
SEX	
RACE	
EDUCATION	
RELIGION	
DATE OF BIRTH	
DATE OF DEATH	
PLACE OF BIRTH	
PLACE OF DEATH	
CAUSE OF DEATH	
DATE OF INTERMENT	
PLACE OF INTERMENT	

RECEIVED

APR 27 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

3953

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>16 Old Chester Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Florence</u> (Middle) <u>Percival</u> (Last) <u>Safford</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>20</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug. 3, 1870</u>
9. AGE last birthday <u>80</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Brooklyn, New York</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Note Teller -</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Percy Safford</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kimball</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT AND ADDRESS <u>Miss Ruth McGowan. (same)</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Paralytic Pleus from Myocardial Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

24 hr.

Antecedent cause(s)

(b) Cardiac Decompensation - Acute2 days.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) Rheumatic Heart Disease - Chronic - C Cardiac Hypertrophy70 yrs.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Generalized Arterio Sclerosis - Arthritis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 1, 1950, to 20 April, 1951, that I last saw the deceasedalive on 19 April, 1951, and that death occurred at 8:00 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

John B. BallM.D.7931 Georgetown Rd Bethesda Md. 2081423. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5-8-51Bessie M. ThompsonRobert A. Humphrey Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED

MAY 10 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

3954

1. PLACE OF DEATH- COUNTRY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>WASHINGTON</u> COUNTY <u>D.C.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EVENTIDE NURSING HOME</u>		STREET ADDRESS (If rural, give location) <u>901 PERRY PLACE, N.E.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JAMES</u> <u>DALLAS</u> <u>SHIRLEY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL</u> <u>23</u> <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>11/30/1865</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>82</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John H. Shirley</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>J. Dallas Shirley (Son)</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Uremia, Hypostatic Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

4 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

Long-term heart failure
Generalized arteriosclerosis, myocardial
thrombotic heart disease

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Smoking

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Apr 8, 1951, to Apr 28, 1951, that I last saw the deceased alive on Apr 28, 1951, and that death occurred at 7:35 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>5-1-51</u>	<u>5-1-51</u>	<u>Heavenly Cem</u>	<u>Washington D.C.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4-28-51</u>	<u>J. William Dodd</u>	<u>The S.H. Hiner Co</u>	<u>2401 14TH ST NW WASH. D.C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

3955

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Washington</u> D.C. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u> D.C.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Leland Pharmacy</u>		STREET ADDRESS (If rural, give location) <u>4701 Butterworth Pl. N.W.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>LEVIN</u>	(Middle) <u>J.</u>	(Last) <u>SOTHORON Jr.</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	4. DATE OF DEATH (Month) <u>Apr</u> (Day) <u>3</u> (Year) <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Drug Store-</u>	8. DATE OF BIRTH <u>5 Oct 1903</u>	9. AGE last birthday (If under 1 year) <u>47</u> yrs. (If under 24 hrs) <u>5</u> Months <u>28</u> Days <u>28</u> Hours <u>19</u> Mins.
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>	
13. FATHER'S NAME <u>Levin J. Sothorn Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Marguerita Tayloe</u>	
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>578-01-5944</u>	
17. INFORMANT AND ADDRESS <u>Martha E. Sothorn (same as item 2)</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hemorrhage due to bullet wound

Antecedent cause(s)

(b) Thin skull

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS

PRIMARY OR CONTRIBUTING CAUSE OF DEATH

PLACE (Home, farm, factory, street, office, bldg., etc.)

INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)

OF INJURY Apr 3 5:16:40 P.m.

INJURY OCCURRED

While at work ☒ Not while at work ☐

HOW DID INJURY OCCUR?

Self-inflicted gun shot wound

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION

REMOVAL (Specify)

Burial

DATE THEREOF

6 Apr 1951

NAME OF CEMETERY OR CREMATORY

Washington National

LOCATION (City, town, or county)

Suitland

(State)

Md.

DATE REC'D BY LOCAL REG.

4-4-51

REGISTRAR'S SIGNATURE

Helin Kurvaach

24. FUNERAL DIRECTOR

Robert A. Humphrey

ADDRESS

Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

073669

FEDERAL
CIVIL SERVICE

RECEIVED
APR 9 1951
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

3956

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Silver Spring		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Silver Spring	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8615 Piney Branch Road		STREET ADDRESS (If rural, give location) 8615 Piney Branch Road	
3. NAME OF DECEASED (Type or Print) Samuel Greene Spear		4. DATE OF DEATH (Month) April (Day) 27 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH July 11, 1877
9. AGE last birthday 73 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouseman - Consultant	10b. KIND OF BUSINESS OR INDUSTRY Own business
11. BIRTHPLACE (State or foreign country) Jamaica Plains, Mass.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Spear		14. MOTHER'S MAIDEN NAME Josephine Rhodes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY No. 022-07-5538	
17. INFORMANT AND ADDRESS Mrs. Beulah B. Spear, 8615 Piney Branch Rd		Silver Spring, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion	INTERVAL BETWEEN ONSET AND DEATH sudden death
Antecedent cause(s) (b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE **Frank J. Bruchart M.D.** ADDRESS **Yarrowburg Md** DATE SIGNED **4-27-51**

23. BURIAL, CREMATION REMOVAL (Specify) Trans. & Burial	DATE THEREOF 4/30/51	NAME OF CEMETERY OR CREMATORY Central Cemetery	LOCATION (City, town, or county) (State) Millbury, Norfolk Co. Mass.
DATE REC'D BY LOCAL REG. 4/30/51	REGISTRAR'S SIGNATURE Francis C. Miller	24. FUNERAL DIRECTOR Warner C. Humphrey	ADDRESS 8434 Ga. Ave., Silver Spring Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 1 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH - COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>D.C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Alta Vista Nursing Home 9200-Old Georgetown Rd.</u>		STREET ADDRESS (If rural, give location) <u>4441-Brandywine St. N.W.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Annie</u> (Middle) <u>L</u> (Last) <u>Steidel</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>4-24-51</u> 19	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>3-6-1890</u>
9. AGE last birthday <u>81</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benny B. Stein</u>		14. MOTHER'S M maiden NAME <u>Mary Ellen Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Gertrude Litten, 4441 Brandywine St. N.W., Washington D.C.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4500 Immediate cause

(a) Acute pulmonary edema

INTERVAL BETWEEN ONSET AND DEATH

4 hrs

Antecedent cause(s)

(b) Generalized arterio-sclerosis

10 years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) Vascular occlusion left ankle

48 hrs

(d) Chronic rheumatoid arthritis

15 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 5, 1938, to Apr 24, 1951, that I last saw the deceasedalive on Apr 24, 1951, and that death occurred at 4:32 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Apr 25/51Frances Potter4535 Yuma St. N.W. Wash DC 4/24/51

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 27 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

3958

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Virginia</u> COUNTY <u>King George</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dahlgren</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>4002 4th Street</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Donna</u> (Middle) <u>Blanche</u> (Last) <u>STEPHENSON</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>30</u> , (Year) <u>19 51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Apr 8, 1951</u>
9. AGE last birthday <u>00</u> yrs. <u>00</u> months <u>22</u> days		10. If under 1 year: Hours <u>00</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Daniel G. STEPHENSON</u>		14. MOTHER'S MAIDEN NAME <u>Irene A. VAVASIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>- - - - -</u>		16. SOCIAL SECURITY NO. <u>- - - - -</u>	
17. INFORMANT AND ADDRESS <u>Father: Daniel G. STEPHENSON</u>			

18. MEDICAL CERTIFICATION Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) ImmaturityAntecedent cause(s) (b) 776XDiseases or conditions, if any, giving rise to the above cause stating the underlying cause last 159II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Apr 8, 1951, to Apr 30, 1951, that I last saw the deceased alive on Apr 30, 1951, and that death occurred at 1:15 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

L. W. SEDERSTROM, LT, MC, USN U.S. NAVAL HOSPITAL May 1, 1951

23. BURIAL CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>May 1, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Angier Cemetery</u>	LOCATION (City, town, or county) (State) <u>Angier, North Car.</u>
DATE REC'D BY LOCAL REG. <u>May 1, 1951</u>	REGISTRAR'S SIGNATURE <u>Elak Whittington</u>	24. FUNERAL DIRECTOR <u>R. A. Pumphrey</u>	ADDRESS <u>Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

MAY 2 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SILVER SPRING</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SILVER SPRING</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>607 SCHUYLER</u>		STREET ADDRESS (If rural, give location) <u>607 SCHUYLER</u>	
3. NAME OF DECEASED (Type or Print) <u>JANE FINLAYSON</u>		4. DATE OF DEATH (Month) <u>APRIL</u> (Day) <u>7</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JUNE 14 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	9. AGE last birthday <u>79</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>ROBERT FINLAYSON</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET DITCH BURN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>NO</u>	
17. INFORMANT AND ADDRESS <u>MR ALEXANDER McDONALD STEWART</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause	(a) <u>CARDIAC - COMPLETE DISSOCIATION (SECOND)</u>	<u>11 HOURS</u>	
Antecedent cause(s)	(b) <u>PULMONARY INFARCTION (FIRST TIME)</u>	<u>11 "</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>TERMINAL PNEUMONIA (NON-INFECTIOUS)</u>	<u>10 "</u>	
II. OTHER SIGNIFICANT CONDITIONS	<u>" PLEURISY (" ")</u>	<u>10 "</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
<u>NONE</u>	<u>—</u>		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
<u>NO</u>	<u>—</u>	<u>—</u>	<u>—</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>—</u>	

22. I hereby certify that I attended the deceased from JAN., 1943., to APRIL 7, 1951., that I last saw the deceased alive on APRIL 7, 1951., and that death occurred at 8 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>April 10, 1951</u>	<u>Morning side Cemetery</u>	<u>24 Boies</u>	<u>Bowie</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>April 9, 1951</u>	<u>Frances Pickett</u>	<u>John H. Walters</u>	<u>254 Carroll St., Totowa Park, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

RECEIVED
JUN 11 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

3960

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH- CITY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1508-Ballard St..</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>DC.</u> COUNTY <u>WASHINGTON</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u> TOWN STREET ADDRESS (If rural, give location) <u>2501-14th St NW, Apt 10</u>	
3. NAME OF DECEASED (Type or Print) <u>Emma</u> (First) <u>Edmedia</u> (Middle) <u>Stutzman</u> (Last)		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 28, 1865</u> 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>No</u>	
		17. INFORMANT AND ADDRESS <u>Mr. Frank Roy Stutzman-1315-K-St. NW</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Viral Pneumonia

Antecedent cause(s)

(b)

Arterio-sclerotic Heart disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

8 days5 yrs.II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1-10, 1951, to 3/31, 1951, that I last saw the deceased alive on 3/31, 1951, and that death occurred at 7:25 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>Apr 3/51</u>		<u>Rock Creek Cemetery</u>		<u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REG. <u>4/1/51</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		24. FUNERAL DIRECTOR <u>S. H. Hunter Co.</u>		ADDRESS <u>2901-14th St. NW</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 4 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3961

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital Bethesda, Md.</u>		STREET ADDRESS (If rural, give location) <u>21 Lawrence Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u> (Middle) <u>R.</u> (Last) <u>Thompson</u>	4. DATE OF DEATH (Month) <u>4</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Oct 2 1925</u> yrs. <u>75</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John R. Thompson</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Murphy</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT AND ADDRESS <u>Charles Thompson - Bethesda, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Generalized arteriosclerosis, with uremia Interval between onset and death Several years

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION

None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-1-, 1951, to 4-8-, 1951, that I last saw the deceasedalive on 4-8-, 1951, and that death occurred at 1:52 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

970246

RECEIVED

APR 16 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

3962

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Silver Spring (Rural)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Silver Spring (Rural)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS CEDARCROFT SANITARIUM		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) Mary DELLA Thompson		4. DATE OF DEATH (Month) (Day) (Year) April 12 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH June 5 1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN Home	9. AGE last birthday 75 yrs.
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Steinbacher		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) No		16. SOCIAL SECURITY No. None --	
17. INFORMANT Hospt. Records			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Cerebral Hemorrhage			12 hrs.
Antecedent cause(s) (b) Arteriosclerosis			?
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **4/6/51**, 19**51**, to **4/12/51**, 19**51**, that I last saw the deceased alive on **4/10/51**, 19**51**, and that death occurred at **8:30 a.m.**, from the causes and on the date stated above.

SIGNATURE (Degree or title) **Richard B. Thibault M.D.** ADDRESS **Cedarcroft Sanitarium Silver Spring Md. 4/12-51** DATE SIGNED **4/12-51**

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town or county) (State)
Burial-Transit	17 Apr 1951	Moorefield Cemetery	Harrison Co. Ohio
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4-17-51	Frances Potter	Robert W. Humphrey	Bethesda, Md.

RECEIVED

MAR 19 1952

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3963

CERTIFICATE OF DEATH

Reg. Dist. No. 288

1. PLACE OF DEATH- COUNTY <u>Montg</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Gaithersburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Gaithersburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Asbury Methodist Home</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Sarah</u> (Middle) <u>Ida</u> (Last) <u>Tomlinson</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>19</u> (Year) <u>51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>June 18/1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>" "</u>	9. AGE last birthday <u>83</u> yrs. If under 1 year Months <u>10</u> Days <u>1</u> If under 24 hrs. Hours <u>1</u> Min. <u>0</u>
11. BIRTHPLACE (State or foreign country) <u>Washington/D C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John R. Reeves</u>		14. MOTHER'S MAIDEN NAME <u>Dortha McNutt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Methodist Home Records, Gaithersburg</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral hemorrhage</u>			<u>10 days</u>
Antecedent cause(s) (b) <u>331X 83a</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not-While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from April 10, 1951, to April 19, 1951, that I last saw the deceased alive on April 10, 1951, and that death occurred at 11:45 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>4/21/51</u>	NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>	LOCATION (City, town, or county) <u>Falls Church Va</u>	(State)
DATE REG'D BY LOCAL REG. <u>April 20, 1951</u>		REGISTRAR'S SIGNATURE <u>Abraham L. Cooke</u>		24. FUNERAL DIRECTOR <u>Ernest C. Gartner, Gaithersburg, Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 24 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

3964

Items 11, 13, 14, on:

2411 N. Charles Street, Baltimore

FAN NO. G 132 APR 23 1951 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY <i>Montgomery</i> CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Chesley Chase</i> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place)		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Montgomery</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>Chesley Chase</i> TOWN STREET ADDRESS (If rural, give location) <i>6400 Brookville rd</i>	
3. NAME OF DECEASED (Type or Print) <i>Cora</i> (First) <i>Elizabeth</i> (Middle) <i>Tropell</i> (Last)		4. DATE OF DEATH Month <i>4</i> Day <i>16</i> Year <i>1951</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Oct 25 1865</i>	9. AGE last birthday <i>85</i> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Genl Clerk</i>
11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>William H. Tropell</i>	
14. MOTHER'S MAIDEN NAME <i>J. Prichella Johnson</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <i>6400 Brookville rd</i>					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Acute Corioid failure

Antecedent cause(s)

(b)

Adeno carcinoma of ribs + liver

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Dec 19*, 19*51*, to *Apr 16*, 19*51*, that I last saw the deceased alive on *Apr 16*, 19*51*, and that death occurred at *1:15 P* m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

*C. W. Culver, M.D.**3781 Alvin St NW**4/16/51*

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*April 12, 1951**Frances Potter**W. Hines Co 2901-14 ATRW*

390916

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

RECEIVED
APR 9 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

3965

214

1. PLACE OF DEATH - COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <i>Maryland</i> COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Bolesville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rural Bolesville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <i>Archibald Sterling Turner</i>		4. DATE OF DEATH (Month) <i>4</i> - (Day) <i>3</i> - (Year) <i>1951</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>N.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>June 3, 1883</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>	9. AGE last birthday <i>67</i> yrs. <input type="checkbox"/> If under 1 year Months <input type="checkbox"/> If under 24 hrs. Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Stetson Turner</i>		14. MOTHER'S MAIDEN NAME <i>May Krump</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>214-12-7050A</i>	
17. INFORMANT AND ADDRESS <i>Mrs Prad Turner</i>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *Myocarditis - chronic*

Antecedent cause(s)

(b) *Bernhardson's*

(c) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

2 yrs

8 yrs

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *2/11*, 194*9*, to *4/3*, 19*51*, that I last saw the deceased

alive on *4/1*, 19*51*, and that death occurred at *8 P.* m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. *4-7-51*

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Francis Potter

Warren B. Humphrey 8636 Ga. Ave., Silver Spring

Maryland

MARGIN RESERVED FOR BINDING

VS. A13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7

RECEIVED

APR 12 1944

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY Montgomery County MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN TAKOMA PARK		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN TAKOMA PARK, MARYLAND	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 500 JACKSON AVENUE		STREET ADDRESS (If rural, give location) 500 JACKSON AVENUE	
3. NAME OF DECEASED (First) JAMES (Middle) (Last) TURNER, Jr.		4. DATE OF DEATH (Month) April (Day) 26th (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 3-22-1884
9. AGE last birthday 67 yrs.		10. If under 1 year: Months 13 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing	
11. BIRTHPLACE (State or foreign country) ORANGE, NEW JERSEY		12. CITIZEN OF WHAT COUNTRY United States	
13. FATHER'S NAME JAMES TURNER, SR.		14. MOTHER'S MAIDEN NAME MARY O'LEARY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 148 14 0684	
17. INFORMANT AND ADDRESS Takoma Park, Md.		18. MRS. LEONA BATAILLE-500 JACKSON AVENUE	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) **Uremia**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Hypertensive cardio-vascular renal disease**(c) **Generalized arteriosclerosis**II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, or office bldg., etc.)		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 4-4, 1951, to 4-26, 1951, that I last saw the deceased alive on 4-25, 1951, and that death occurred at 7:35 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) Burial	DATE THEREOF 4-30-51	NAME OF CEMETERY OR CREMATORY Holy Sepuchler Cemetery	LOCATION (City, town, or county) East Orange, New Jersey
DATE REC'D BY LOCAL REG. 4-26-51	REGISTRAR'S SIGNATURE Frances Potter	24. FUNERAL DIRECTOR Martin W. Lysong & Son, Wash, D.C.	ADDRESS 5742 1/2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

APR 30 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>DISTRICT of COLUMBIA</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1508 BALLARD ST.</u>		STREET ADDRESS (If rural, give location) <u>3945 CONN AVE., NW</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ELLA MAGRUDER TURTON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 2 1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>2 1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>DISTRICT of COLUMBIA</u>
13. FATHER'S NAME <u>JOHN BOOTH TURTON</u>		14. MOTHER'S MAIDEN NAME <u>SARAH ANN RAGGLES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS <u>ROB DENHAM - 3945 CONN AVE (D.C.)</u>

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Acute Congestive Heart Failure</u>				<u>10 days</u>
Antecedent cause(s) (b) <u>Arterio-sclerotic Heart disease</u>				<u>15 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertension</u>				<u>15 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 15, 1950, to April 2, 1951, that I last saw the deceased alive on April 1, 1951, and that death occurred at 11:15 A.M. m., from the causes and on the date stated above.

SIGNATURE <u>Francis P. Richards</u> (Degree or title)		ADDRESS <u>777 Columbia Ave N.W. Wash. D.C.</u>		DATE SIGNED <u>4-2-51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>4-5-1951</u>	NAME OF CEMETERY OR CREMATORY <u>OAK HILL CEMETERY</u>	LOCATION (City, town, or county) <u>WASHINGTON, D.C.</u>	(State)
DATE REC'D BY LOCAL REG. <u>Apr 3/51</u>	REGISTRAR'S SIGNATURE <u>Frances Potter</u>	24. FUNERAL DIRECTOR <u>Joe Dawler's Sons, Wash., D.C.</u>		ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

3968

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4401 Fairfield Dr.</u>		STREET ADDRESS (If rural, give location) <u>4401 Fairfield Dr.</u>	
3. NAME OF DECEASED (Type or Print) <u>ISABEL</u> (First) <u>WALKER</u> (Middle) <u>VANDERWERKER</u> (Last)		4. DATE OF DEATH <u>15 April</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>18 Aug 1862</u>
9. AGE last birthday <u>88</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. School Teacher</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Samuel H. Walker</u>	
14. MOTHER'S MAIDEN NAME <u>Mary E. Queen</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)	
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Col. F.H. Vanderwerker Bethesda, Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Acute Congestive Heart Failure</u>		<u>24 hrs</u>
Antecedent cause(s)	(b) <u>Arterio-sclerosis (generalized)</u>		<u>70 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan, 1951, to April 15, 1951, that I last saw the deceased alive on April 15, 1951, and that death occurred at 2:30 P.m., from the causes and on the date stated above.

SIGNATURE Ernest B. Rude (Degree or title) M.D. ADDRESS 3900 Military Rd. DC DATE SIGNED April 16, 51

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 4/17/51 NAME OF CEMETERY OR CREMATORY Congressional LOCATION (City, town, or county) (State) Washington, D.C.

DATE REC'D BY LOCAL REG. 4-16-51 REGISTRAR'S SIGNATURE Helen S. Ebersfeldt 24. FUNERAL DIRECTOR Robert A. Humphrey ADDRESS Bethesda, Md.

MARGIN RESERVED FOR BINDING

VS. A13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

093916

RECEIVED
APR 17 1951
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD.</u> COUNTY <u>Montgo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5312 Western Ave.</u>		STREET ADDRESS (If rural, give location) <u>5312 Western Ave.</u>	
3. NAME OF DECEASED (First) <u>Mary</u> (Middle) <u>K.</u> (Last) <u>Volck</u>	4. DATE OF DEATH (Month) <u>Apr.</u> (Day) <u>7</u> (Year) <u>1951</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>1-24-1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Widow</u>	9. AGE last birthday <u>77</u> yrs. If under 1 year: Months <u>7</u> Days <u>7</u> Hours <u>1</u> Min. <u>7</u>
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christian Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Wallace</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>BAE1 W. OCA'S</u>	
17. INFORMANT <u>BAE1 W. OCA'S</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Cerebral Hemorrhage.</u>		<u>48 hours.</u>
(b) Antecedent cause(s) <u>Hypertensive Heart Disease.</u>		<u>12 years.</u>
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Apr. 10, 1940, to Apr. 7, 1951, that I last saw the deceased alive on 7 April, 1951, and that death occurred at 6:30 P m., from the causes and on the date stated above.

SIGNATURE H. B. Luller M.D. Baltimore Park, Md. ADDRESS Baltimore, Md. DATE SIGNED Apr. 7/1951

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE 4-11-51 NAME OF CEMETERY OR CREMATORY Cedar Hill LOCATION (City, town, or county) (State) Frederick, Md.

DATE REC'D BY LOCAL REG. 4-7-51 REGISTRAR'S SIGNATURE John Kurraach 24. FUNERAL DIRECTOR W. H. Hines Co. ADDRESS 3901-14th St. N.W. WASH. D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

3970

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Virginia</u> COUNTY <u>Arlington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arlington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>567 20th Street, South,</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Denver</u> <u>Lynn</u> <u>WILLIAMS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 14,</u> <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Apr 9, 1951</u>
9. AGE last birthday <u>00</u> yrs. <u>00</u> months <u>00</u> days		10. If under 1 year If under 24 hrs. Hours Min. <u>00</u> <u>00</u> <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - -</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Lester D. WILLIAMS</u>		14. MOTHER'S MAIDEN NAME <u>Madeline Lois LINDLEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>- - - - -</u>	
17. INFORMANT AND ADDRESS <u>Father: Lester D. WILLIAMS</u>			

18. MEDICAL CERTIFICATION Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

770.0 Immediate cause (a) Atelostoma - Complete Left Partial Rupture 1 day

161a Antecedent cause(s) (b) Hernia 2 days

stating the underlying cause last (c) Erythroblastosis Foetalis 5 days

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 9, 1951, to Apr 14, 1951, that I last saw the deceased alive on Apr 14, 1951, and that death occurred at 11:23 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

A. GEDAROVICH, LT, MC, USN U.S. NAVAL HOSPITAL April 16, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Apr 19, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
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DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS
Apr 16, 1951 Elia Whittington R. A. Pumphrey, 7557 Wisconsin Avenue, Bethesda, Maryland.

204091259405

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

APR 18 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

1. PLACE OF DEATH - COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Clarksville</u> OR TOWN <u>Clarksville</u> LENGTH OF STAY (in this place) <u>16 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Clarksville Maryland</u> OR TOWN <u>Clarksville</u> STREET ADDRESS (If rural give location) <u>Bethesda Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>			
3. NAME OF DECEASED (Type or Print) <u>Clifton Delaware Wims</u> (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>April 19 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>MCX 31 76-1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher Clarksville School</u>		11. BIRTHPLACE (State or foreign country) <u>Montgomery Co. Md</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT <u>Emily E Wims Clarksville</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral hemorrhage and laceration</u>			<u>12 hrs</u>
Antecedent cause(s) (b) <u>due to bullet wound in skull</u>			
(c) <u>976X Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office, etc.) <u>home</u>	(CITY OR TOWN) (COUNTY) (STATE) <u>Clarksville Monty Md</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>4-14-51 - 5:51 p.m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Self inflicted gun shot</u>
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE (Degree or title) <u>Frank J. Broesch M.D. Gaithersburg Md</u>		DATE SIGNED <u>4-19-51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>April 21, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>
LOCATION (City, town, or county) (State) <u>Clarksville Md</u>			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>5-1-51</u>		FUNERAL DIRECTOR <u>Roy W. Barker Georgetown Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 8 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216 213

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>4534 Avondale St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Ralph</u> (Middle) <u>Boehm</u> (Last) <u>Wittler</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 6 1951</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>May 16, 1902</u>
9. AGE last birthday <u>48</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Estimator</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Mill work</u>	9. AGE last birthday <u>48</u> yrs. If under 1 year Months <u>10</u> Days <u>20</u> If under 24 hrs. Hours <u>10</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Wittler</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Boehm</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-03-9208</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Sara M. Wittler - 4534 Avondale St.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of Colon with metastases

INTERVAL BETWEEN ONSET AND DEATH

1 year?

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Cirrhosis of Liver

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF INJURY INJURY	(CITY OR TOWN) (COUNTY) (STATE) <u>Bethesda.</u> <u>MTGMPRY</u> <u>MD.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-3, 1951, to 4-6, 1951, that I last saw the deceasedalive on 4-6, 1951, and that death occurred at 10:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Dorothy Gill, M.D.7011 Arlington Rd4-7-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>April 10/51</u>	<u>Western Cemetery</u>	<u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>4-12-51</u>	<u>Helen L. Eklundfeldt</u>	<u>Robert L. Humphrey</u>	<u>Bethesda, Md.</u>

390 626

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 16 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>WESTMORELAND HILLS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>WESTMORELAND HILLS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>35 ELLIOTT ROAD</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JOHANNA</u>	(Middle) <u>R.</u>	(Last) <u>WOOLNOUGH</u>
4. DATE OF DEATH	(Month) <u>Apr</u>	(Day) <u>4</u>	(Year) <u>1951</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, (MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>OCT. 18/70</u>
9. AGE last birthday <u>80</u> yrs.		10. AGE last birthday If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>FERDINAND BAHR</u>		14. MOTHER'S MAIDEN NAME <u>HELENA STOLTZ</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>MISS MARIE F. WOOLNOUGH</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Cerebral hemorrhage</u>	<u>2 weeks</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>arteriosclerosis</u>	<u>1 year</u>
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 15 1950 to April 4, 1951, that I last saw the deceased alive on Apr 4, 1951, and that death occurred at 7:10 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4/9/51</u>	<u>ALBANY RURAL CEMETERY</u>	<u>WATERYLIET N. Y.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>4-4-51</u>	<u>Heleen Kurozak</u>	<u>Francis Collins</u>	<u>3821-14TH ST N.W. WASH. D.C.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Maple Lane Rest Home</u>		STREET ADDRESS (If rural give location) <u>9912 Indian Lane</u>	
3. NAME OF DECEASED (Type or Print) <u>EDNA</u>	(First) <u>C</u> (Middle) <u>WRIGHT</u> (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>4 - 19 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 29, 1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Resident Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Com. Apts</u>	9. AGE last birthday <u>75</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Mathew McEwen</u>		14. MOTHER'S MAIDEN NAME <u>Anna Hyland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>578-09-3929</u>	
(If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Harold M. Morrey, 9912 Indian Lane</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X Immediate cause

(a) Carcinoma of Intestines

Antecedent cause(s)

46a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Sensitivity

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify) none

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY none

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 11, 1950, to April 19, 1951, that I last saw the deceased

alive on April 19, 1951, and that death occurred at 12:18 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Cremation

DATE THEREOF 4/19/51

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Apr 20, 1951

Frances Potter

Warner E. Humphrey

8434 Ga. Ave., Silver Spring Maryland

290836

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

APR 24 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>District of Columbia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lakoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cherry Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium & Hospital</u>		STREET ADDRESS (If rural, give location) <u>3929 Morrison St. N.W.</u>	
3. NAME OF DECEASED (Type or Print) <u>ROSE</u> (First) <u>DALE</u> (Middle) <u>YOST</u> (Last)		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>3</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>9-9-71</u>
9. AGE last birthday <u>79</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Fairview West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Yost</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Neptune</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Earnest L. Yost (SON)</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Shinerticulitis & Hemorrhage</u>		<u>3 weeks</u>	
Antecedent cause(s) (b) <u>572.1</u> <u>123</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>14 Mar, 1951</u> , to <u>3 April, 1951</u> , that I last saw the deceased alive on <u>1 April, 1951</u> , and that death occurred at <u>6:45 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Edward L. Wilson</u>		ADDRESS <u>21801 Eye St N.W. Wash. D.C.</u>	
DATE SIGNED <u>23 April 51</u>			
23. BURIAL CREMATION REMOVAL (Specify) <u>4-4-51</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem</u>	
LOCATION (City, town, or county) (State) <u>Farmont Md</u>			
DATE REC'D BY LOCAL REG. <u>4-3-51</u>		REGISTER'S SIGNATURE <u>J. H. H. H. H. H.</u>	
24. FUNERAL DIRECTOR <u>The S. H. Hines Co.</u>		ADDRESS <u>Washington D.C.</u>	

MARGIN RESERVED FOR BINDING

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VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

